Silent Wing Energy Medicine

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Name ____ Today's Date: ____/____/_____

Street Address ____

City ___________________ State _____ Zip ________ Email __________________________

Home Phone ____________________ Work Phone ____________________

Age __________ Birth date ____/____/_____ Male/Female Ht: ______ Wt: _______

Referred By? ______________________ Occupation: ______________________________

Reason for your visit today? ____

How long have you had this condition? ____

Is it getting worse? Yes/No Does it bother your: Sleep/Work/Other: ___________________________

What seemed to be the initial cause? ____

What seems to make it better? ____

What seems to make it worse? ____

What medicines or therapies have you tried so far to address your condition? _______________________

____

Have you been treated with acupuncture before? Yes/No Chinese Herbal Medicine? Yes/No

Are you under the care of a physician now? Yes/No If yes, for what? _________________________

Who is your physician? ____________________________ Phone: ______________________

FAMILY MEDICAL HISTORY

Alcoholism	Arteriosclerosis	Diabetes	High Blood Pressure
Allergies	Asthma	Heart Disease	Stroke
	Cancer	Seizures	

Other: ____

YOUR MEDICAL HISTORY

Mark the following conditions you currently have, or have had in the past. Please also mark if you feel any of the following were a significant part of your family medical history. **N = Now, P = Past, F = Family.**

____ Addiction	____ Birth Trauma	____ Herpes	____ Mumps	____ Seizures
____ AIDS/HIV	____ Cancer	____ High Blood Pressure	____ Oral Contraceptive Use	____ Stroke
____ Alcoholism	____ Frequent Colds	____ Infections Slow to Heal	____ Overseas Travel	____ Tuberculosis
____ Allergies	____ Chronic fatigue	____ Low Adrenal Function	____ Pleurisy	____ Thyroid disorders
____ Appendicitis	____ Contraceptive Patch	____ Measles	____ Pneumonia	____ Typhoid fever
____ Anemia	____ Emphysema	____ Mononucleosis	____ Polio	____ Ulcers
____ Kidney disease	____ Epilepsy	____ Multiple Sclerosis	____ Rheumatic Fever	____ Sexually Transmitted Disease
____ Appendicitis	____ Goiter		____ Scarlet Fever	
____ Arteriosclerosis	____ Heart Disease			
____ Asthma	____ Hepatitis			

Other: ____

SURGERIES, HOSPITALIZATIONS, AND MAJOR INJURIES (Date as MM/YY, Describe in a few words)

Surgeries, Sports Injuries	Major Traumas (car, fall, etc.)	Hospitalizations in last 2 years:
____	____	____
____	____	____
____	____	____
____	____	____
____	____	____

FAVORITE FOODS IN YOUR DAILY MENU

Breakfast	Lunch	Afternoon Snacks	Dinner	Late Snacks

YOUR DIET, MEDICATIONS, AND LIFESTYLE

Mark any of the following drugs and medications you are using now:

Antacids
Insulin
Anti-inflammatories
Antibiotics/Anti-fungals
Anti-depressants
Aspirin/Tylenol
Chemotherapy
Cortisone (Oral or shots)
Heart Medications
High Blood Pressure
Hormones
Laxatives
Anti-anxiety
Oral Contraceptives
Radiation Therapy
Recreational Drugs
Relaxants/Sleeping Pills
Thyroid Medication
Ulcer Medications
Under-wire Brassieres

Please mark if you eat, drink or use any of these regularly or in large amounts:

Alcohol
Artificial Sweeteners (Splenda, Sucralose, Aspartame, etc.)
Cellular Phone
Dairy Products (Milk, Cheese, etc.)
Cigars or Cigarettes
Coffee ______ Cups/day?
Water ______ Cups/day?
Soy infant formula
Carbonated Drinks or Fizzy Water
Diet Drinks
Bottled Water
Soy Milk, Soy Sauce, Tofu, or TVP
Fast Food (More than twice a week)
Chocolate
Margarine
A microwave oven
Sweets, cookies, candy
Vitamins and/or Mineral Supplements *
Herbal Supplements *
Low Carbohydrate Products
Filtered/Distilled Water

* Please list **ALL** the Prescription Medications, Vitamins, and Supplements you are taking now (Use an additional sheet if needed):

____
____
____

Mark if You:

Are currently trying to lose weight
Do NOT exercise regularly
Salt food w/o tasting
Are under a lot of stress
Are, or were in the past, exposed to chemicals at work
Are, or were in the past, regularly exposed to second hand smoke
Have a regular religious or spiritual practice
Spend regular time outdoors
Have a supportive relationship

GENERAL SYMPTOMS (Circle Appropriate Choice if More than One in an Item, i.e. Tend to Feel Hot/Cold)

Strong Thirst
Dislike drinking water
Tend to Feel Hot/Cold
Drink a Lot of Cold/ Hot Drinks
Poor/Heavy Appetite
Recent Weight Loss/Gain
Hard to Fall Asleep
Hard to Stay Asleep
Difficulty Waking Up
Do NOT Wake rested
Hours sleep/night? ___
Dream-disturbed sleep
Fatigue/Low Energy
Lack of Strength
Bodily Heaviness
Cold Hands or Feet
Poor Circulation
Shortness of Breath
High/Mild Fever
Body Aches
Chills
Night Sweats
Sweat Easily/ w/out Exertion
Feel warmer in afternoon/bedtime
Poor Memory/Hard to Think Clearly
Dizziness
Bruise/Bleed Easily

What time of day do you feel best/are your symptoms at their least? ______________________

What time of day do you feel worst/are your symptoms at their strongest? ______________________

HEAD - EYES - EARS - NOSE - THROAT

Eye Strain
Eyes Sensitive to Light
Dry/Red Eyes
Itchy Eyes
Spots in Eyes
Poor Vision
Blurred Vision
Poor Night Vision
Glaucoma

Cataracts
Teeth problems
Grinding Teeth
TMJ
Facial Pain
Gum Problems
Sores on lips or tongue
Dry Mouth/Throat
Sinus Problems

Nose Bleeds
Excessive Phlegm
Color of Phlegm: ________________
Recurrent Sore Throat
Swollen Glands
Lumps in Throat
Enlarged Thyroid

Ringing in Ears
Hearing Loss
Earaches
Headaches
Migraines
Head Injury

Other: ____

RESPIRATORY

Runny Nose
Nasal Congestion
Breathe through Mouth
Short of Breath
Wheezing
Frequent Colds
Pneumonia

Hard to Breathe Lying Down
Tightness in Chest
Can't breathe only through your nose?
Coughing Blood
Chronic Lung

Congestion
Pain on Breathing
Sinus Headaches
Allergies/Hay fever
Cough
If yes, Wet or Dry ________________

Thick or Thin Sputum? ________________
Recent Color of Phlegm? ________________

Other: ____

CARDIOVASCULAR

Fainting
Chest Pain/Angina
Difficulty Breathing
Tire w/ Little Exertion
Rapidly Beating Heart

Heart Pounds Forcefully
High Blood Pressure
Low Blood Pressure

Blood Clots
Narrowing of Arteries
Heart Misses Beats or Has Extra Beats
Phlebitis

Deep Leg Pain
Heart Surgery
Heart Attack
Stroke

Other: ____

SKIN & HAIR

Dry Skin/Hair
Change in Skin Color

Eczema/Hives
Acne
Itching

Bruise Easily
Rashes
Ulcerations

Numbness
Fungal Infections
Hair Loss

Multiple bad Sunburns

Other: ____

GASTRO-INTESTINAL

Low/No appetite
Lost Sense of Smell
Can't Taste Food
Excessive Appetite
Tired after Eating
Sugar Cravings
Bloating
Flatulence

Headache after Eating
Nausea
Bad Breath
Vomiting
Acid Stomach
Hiccups
Belly Pain
Cramps
Belching

Stomach Pain when Emotionally Upset
Difficulty eating Rich/Fatty Foods
Diarrhea (Watery)
Soft Pasty Stool
Constipation
Hard, Painful Stool

Alternating Diarrhea & Constipation
Laxative Use
Hemorrhoids
Bowel Movements:
Per day: ______
Color ________
Odor _________

Itchy/Burning Rectum
Black, Tarry Stools
Red Bloody Stools
Mucous in Stool
Rectal Pain
Use a fiber supplement

Other: ____

MUSCULO-SKELETAL (If this is your Main Health Concern, Please Mark all the Areas of Pain on the Body Map on Last Page)

Muscle pain
Muscle Cramps
Joint Pain
Arthritis
Loss of Strength

Restless Legs
Limited Range of Motion
Spasms/ Numbness

Lost Muscle Mass
Neck/Shoulder Pain
Pain Disturbs Sleep

Upper Back pain
Hip Pain
Sciatica
Low Back Pain
Surgery

Disk damage (Spinal Level? Films taken?)

Other: ______________________________

NEURO-PSYCHOLOGICAL

Tension
Numbness
Seizures
Tingling/ Burning in Hands/feet
Poor Memory

Depression
Anxiety
Panic Attacks
Frustration
Sadness
Chronic Worry

Irritability
Headaches
Large mood swings
Easily Stressed
Difficulty Sleeping

Mind Won't Stop/ Lie Awake Thinking
Abuse Survivor
Considered/ Attempted Suicide
Eating Disorders
Eat for Emotional Comfort

Are You Currently In Counseling? ______
(Please Detail below)

Other: ______________________________

GENITO-URINARY

Pain on Urination
Frequent Urination
Urgent Urination
Blood in Urine
Unable to Hold Urine

Incomplete Urination
Dribbling after Urination
Kidney or Bladder Infections
Kidney Stones

Bedwetting
Wake to Urinate
Pain in Side
Pain/Coldness in Genital Area
Pain with Intercourse

Venereal Disease
Change in Sex Drive
Difficulty Conceiving

MEN ONLY
Impotence
Erectile Dysfunction
Nocturnal Emission
Premature Ejaculation

Other: ______________________________

GYNECOLOGY (In Oriental Medicine, this is a powerful window into women's health in general. If you have reached menopause or had surgery, and no longer have periods, please note that AND report what your typical periods WERE like.)

Age Menses began ______
Date last period began: ______
Age at Menopause ______
Typical periods (even if menopausal):
Length of Cycle (from day 1 - day 1) ______ days
Irregular Cycle Length
Duration of Flow: ______ days
Painful periods
Light Menstrual Flow
Bleeding between Cycles
Clots with Flow
Heavy Menstrual Flow

Endometriosis
Anxiety about Menstrual Cycle
Vaginal Odor
Frequent Vaginal Infections
Vaginal Itching
Vaginal Discharge (color): ______
Vaginal Sores
Tender Breasts
Breast Lumps
Nipple Discharge

PMS
Do you think or know that you are pregnant now?
Total Number of Pregnancies: ______
# of Live Births: ______
# of Premature Births: ______
# of Abortions: ______
Large Blood Loss Complications
Hysterectomy
Date of Last PAP: ______
Results? ______
______
______

Other: ______________________________

STRESS - How would you characterize the current level of stress in your life?

Minimal Stress	High Stress
Moderate Stress	Intolerable Stress

What are your major sources of stress?

Work	Primary Relationship	Personal Health Issues
School	Family/Children	Family Health Issues
Choosing a New Career	Taking Care of Parents/Spouse	Finances

Other: ______________________________

MANAGING STRESS - What do you do to relax? Please check all that apply.

Watch TV or a Movie	Meditate	Spend time w/ a Hobby	Get a Massage	Go out with Friends
Eat Chocolate/Sugar	Read Books	Take a Tranquilizer	Sleep In	Work in the Garden
Deep Breathing	Get Acupuncture	Work Out/ Exercise	Listen to Music	Play Sports
Dine Out	Use Recreational Drugs	Do Yoga	Play Music/Sing	
Go Shopping	Smoke Tobacco	Watch Sports	Take a Nap	
Have a drink or two	Spend Time Outdoors		Play with Kids	
			Spend time with pets	

Other: ______________________________

NATURAL/ENERGETIC MEDICINE - What have you tried/used in the past?

Acupuncture	Massage	Reiki	Chinese Herbs	Breath work
Meditation	Cranio-Sacral Work	Homeopathy	Western Herbs	Hydrotherapy
Yoga	Life Coaching	Crystals/gemstones	Rebirthing	Sound therapy
Chiropractic	Polarity Therapy	Essential Oils	Whole foods diet	

Other: ______________________________

YOUR GOALS

As you start treatment, please share any personal goals have you set for treatment -- results you'd like to see.

You may choose to rely solely on the effects of treatments to improve your health condition, however, your active participation in your healing can both speed up and increase the overall potential for positive change. Please tell me honestly: How much effort in self-care, and even possibly lifestyle change, are you are willing to make to support positive changes in your health?

MINIMAL SOME QUITE A BIT WHATEVER IT TAKES

What are your passionate interests in life?

Is there anything else that is important for you to share about yourself or your condition that was not covered in this questionnaire? Feel free to use extra sheets of paper if you need them.

BODY PAIN and SCAR CHART – Using a BLUE PEN, please mark with an X, the location(s) of pain in your body. Locate as closely as you can the center of the pain. Then CIRCLE all the known scars on your body.