

# IHA Health/Stress Survey Form

Date: \_\_\_\_\_

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_ Occupation: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Would you like to receive information on how to get well and stay healthy? YES NO

1. Have you ever acupuncture or oriental medicine? YES NO Date: \_\_\_\_\_

2. Are you currently under any health care? YES NO Type: \_\_\_\_\_

3. Please check any of the following you currently have (or had) in the past year:

- |   |  |
|---|--|
| <input type="checkbox"/> Allergies                  | <input type="checkbox"/> Ankle / Foot Pain         |
| <input type="checkbox"/> Back Pain                  | <input type="checkbox"/> Menstrual Problems / PMS  |
| <input type="checkbox"/> Cold Hands & Feet          | <input type="checkbox"/> Neck Pain / Stiffness     |
| <input type="checkbox"/> Digestive Problems         | <input type="checkbox"/> Skin Problems             |
| <input type="checkbox"/> Elbow Pain                 | <input type="checkbox"/> Stress / Tension          |
| <input type="checkbox"/> Fatigue                    | <input type="checkbox"/> TMJ / Jaw Pain            |
| <input type="checkbox"/> Headaches / Migraine       | <input type="checkbox"/> Hip Pain                  |
| <input type="checkbox"/> Muscle Pain / Tension      | <input type="checkbox"/> Knee Pain                 |
| <input type="checkbox"/> Wrist Pain / Hand Numbness | <input type="checkbox"/> Drug / Alcohol / Smoking  |
| <input type="checkbox"/> Sleeping Problems          | <input type="checkbox"/> Arthritis / Bursitis      |
| <input type="checkbox"/> Breathing Problems         | <input type="checkbox"/> Heart Problems            |
| <input type="checkbox"/> Dizziness                  | <input type="checkbox"/> Infertility               |
| <input type="checkbox"/> Pain Down The Legs / Arms  | <input type="checkbox"/> Shoulder Pain / Stiffness |
| <input type="checkbox"/> Genitourinary: _____       | <input type="checkbox"/> Cardiovascular: _____     |
| <input type="checkbox"/> Other Pain: _____          | <input type="checkbox"/> Other Condition: _____    |

4. These Problems affect my:

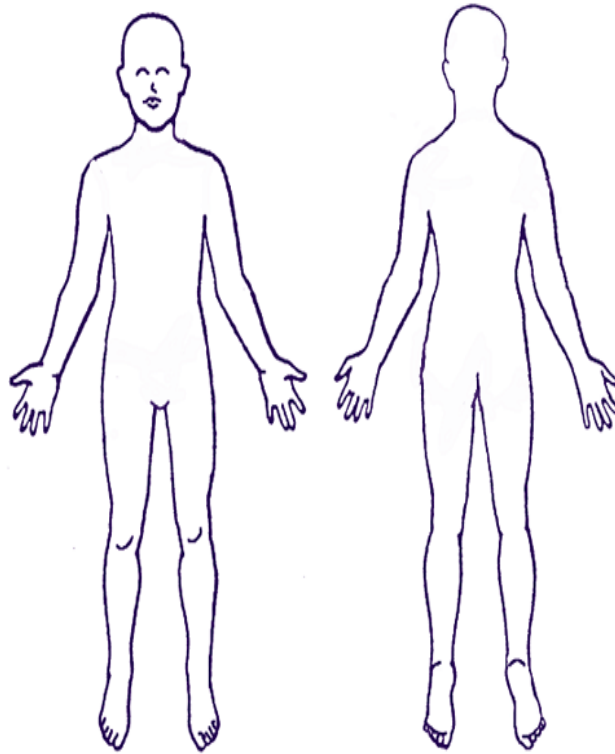
- |                                     |                                   |                                   |
|-------------------------------------|-----------------------------------|-----------------------------------|
| <input type="checkbox"/> Home Life  | <input type="checkbox"/> Patience | <input type="checkbox"/> Energy   |
| <input type="checkbox"/> Work Life  | <input type="checkbox"/> Family   | <input type="checkbox"/> Attitude |
| <input type="checkbox"/> Activities | <input type="checkbox"/> Sleep    |                                   |

5. On a scale of 1 -10, how committed are you to correcting this problem?

Not committed    1 2 3 4 5 6 7 8 9 10    Very committed

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6. Please circle where you have pain, tension or discomfort:



Anatomical Chart

If you checked any of the above items, you are probably not functioning at your optimum. The good news is our integrated medical approach may help since it is designed to gently and naturally treat the body to remove stress and restore balance.

Would you like to get rid of the problem? YES NO

If you answered YES, there are several alternatives available to you. Please check the most appropriate for you:

*I would like to come to the office for an initial consultation. There is NO CHARGE for this visit. This will allow me to find out if I can be helped by integrative medicine without any financial barriers.*

*I would like to come for a wellness class or lecture.*

*I would like the doctor/therapist to call me to discuss my health problem before making an appointment.*

**Please Print & Fax To: 954-473-5993**