LONGMONT HEALING ARTS CLINIC
Barbara Blunt Vaelli, ND, LAc
736 Kimbark Street
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~~~HEALTH HISTORY QUESTIONNAIRE~~~

Please help us provide you with a complete evaluation by taking the time to fill out this questionnaire carefully. All of your answers will be held absolutely confidential.
If you have any questions, please ask.

Date: _____

Name:_____ **F** **M**

Street:_____ City:_____

State:_____ Zip:_____

Phone:_____

E-mail:_____

Date of Birth:_____ Height:_____ Weight:_____

Occupation:_____

Please circle: Single Married Life Partner Divorced Widowed
Other -

Name of Significant Other:_____

Names and ages of Children:_____

In Emergency Notify:_____

Phone:_____ Relationship:_____

Primary Care Doctor:_____

How did you here about our clinic?_____

List Your Present Health Concerns in Order of Importance:

1. _____ Began: _____

What makes the condition better?_____

What makes the condition worse?_____

Other comments:_____

2. _____ Began: _____

What makes the condition better?_____

What makes the condition worse?_____

Other comments:_____

3. _____ Began: _____

What makes the condition better?_____

What makes the condition worse?_____

Other comments:_____

4. _____ Began: _____

What makes the condition better?_____

What makes the condition worse?_____

Do you have any opinions or ideas regarding what has caused your concerns/conditions?

_____

_____

_____

List any chronic conditions, diseases or illnesses you have been previously diagnosed with:

_____

_____

_____

Surgeries and/or hospitalizations:
Date **Type**

Accidents or falls and type of injury:
Date **Type**

Medications with dosages:

Supplements, herbal formulas or homeopathic remedies:

List any known allergies or sensitivities (Medications/Environmental/Chemical/Food):

FAMILY HISTORY:
Please give information on biological family, if known:

Mother: Living_____ Deceased_____ Age_____
Reason for death, if deceased_____
Any pronounced illnesses:_____

Father: Living_____ Deceased_____ Age_____
Reason for death, if deceased_____
Any pronounced illnesses:_____

Mother's father: Living_____ Deceased_____ Age_____
Reason for death, if deceased_____
Any pronounced illnesses:_____

Mother's mother: Living_____ Deceased_____ Age_____
Reason for death, if deceased_____
Any pronounced illnesses:_____

Father's father: Living_____ Deceased_____ Age_____
Reason for death, if deceased_____
Any pronounced illnesses:_____

Father's mother: Living_____ Deceased_____ Age_____
Reason for death, if deceased_____
Any pronounced illnesses:_____

Siblings: Please list any significant illnesses

Aunts/Uncles: Please list any significant illnesses

SLEEP HISTORY:
Number of hours of sleep per night_____ Wake refreshed? **Y N** _____
Do you have difficulty falling to sleep? **Y N** If yes, why?_____
Do you have difficulty staying asleep? **Y N** If yes, why?_____
Please describe your energy levels throughout the day (0 - extremely exhausted / 10 - ideal energy):
Awakening_____ Morning_____ Midmorning_____ Noon_____
Afternoon_____ Evening_____ Night_____ At bedtime_____
Do you have any of the following? (Please circle)
Nightmares Recurring dreams Sleep talking Sleep walking Grind teeth Leg restlessness or cramps
Do you have any more comments about your sleeping health?_____

DIGESTIVE HISTORY:
How many bowel movements do you have per day?_____ Any blood? **Y N** Any mucus? **Y N**
What is the consistency of your stools? Hard Firm Soft Runny
Are they well-formed? **Y N** Do you ever have tiny pellets? **Y N** Do your stools: float? sink? both?
When your digestive system is 'off' do you tend towards: constipation or loose stools/diarrhea?
Please circle if you are presently experiencing or have reoccurring symptoms of:
excessive gas bloating nausea vomiting jaundice hernias abdominal pain pain during bowel movement hemorrhoids heartburn belching acid reflux
Other?_____

DIET HISTORY:
Are you satisfied with your present diet? **Y N** Are you satisfied with your present weight? **Y N**
Does your weight fluctuate? **Y N** If yes, please describe
_____

TWENTY-FOUR HOUR DIET RECALL:
Please write down what you have eaten in the last twenty-four hours, include all beverages and snacks. If it is presently the middle of the day, write down what you had for dinner, etc. the previous day.
Breakfast –

Lunch –

Dinner –

Snacks –

Is this a typical day? **Y N** If no,
explain_____
_____
_____

Please circle appropriate answer and complete:

Consume alcohol?	**Y**	**N**
Smoke?	**Y**	**N**
Drink coffee?	**Y**	**N**
Consume sugar?	**Y**	**N**
Artifical sweetners?	**Y**	**N**
Fast food?	**Y**	**N**
Drink soda pop?	**Y**	**N**
Drink water?	**Y**	**N**
Fried foods?	**Y**	**N**
Margarine?	**Y**	**N**
Red meat?	**Y**	**N**
Poultry?	**Y**	**N**
Fish?	**Y**	**N**

Organic Food? Never Sometimes Most often All of the time

Dietary restrictions? **Y N** Explain:_____
Food cravings? **Y N** Explain:_____
Food aversions? **Y N** Explain:_____

Aspirin/ibuprofen? **Y N**
Use other pain medications? **Y N** Explain:_____

Do you exercise? **Y N** What type(s)/How often _____
_____

What is your stress level? (0 – no stress / 10 – extreme stress) **0 1 2 3 4 5 6 7 8 9 10**

What activities, if any, do you do for stress and anxiety?_____

Instructions: **Please circle, check or highlight any symptoms you have presently or that reoccur on a regular basis.**

Head/Neurological

1. Head feels heavy
2. Light headedness/fainting
3. Dizziness/Loss of balance
4. Ringing in ears
5. Trembling in hands or feet
6. Double vision
7. Headaches
8. Night Blindness
9. Eye pain/Itching
10. Eye dryness
11. Floating 'dots' in vision
12. Halos or lights in eyes
13. Blurry vision
14. Glaucoma
15. Cataracts
16. Light sensitivity
17. Swollen eyes
18. Circles under eyes
19. Poor concentration
20. Poor memory
21. Slurred speech
22. Jaw pain

Respiratory

1. Difficulty breathing
2. Chronic cough
3. Coughing phlegm/blood
4. Shortness of breath
5. Painful breathing
6. Asthma
7. Allergies
8. Bronchitis
9. Pneumonia
10. Tuberculosis
11. Frequent chest colds
12. Exposure to chemicals

Genito-Urinary

1. Frequent urination
2. Wake to urinate
3. Pain on urination
4. Brown, black or bloody urine
5. Bladder infections
6. Constant urge to urinate
7. Unable to urinate
8. Bed wetting
9. Urination on laughing/sneezing/coughing
10. Kidney infections/stones

Sinus/Ear/Nose/Throat

1. Frequent colds
2. Sore throats
3. Sore or bleeding gums
4. Nose pain
5. Nose bleeding
6. Nose discharge
7. Frequent blowing nose
8. Difficulty breathing through nose
9. Earaches
10. Ringing in ears
11. Canker sores
12. Fever Blisters
13. Dental problems
14. Difficulty swallowing
15. Hayfever/Allergies
16. Post nasal drip
17. Loss of taste

Skin

1. Rashes
2. Hives
3. Dryness
4. Itching
5. Bruise easily
6. Loss of hair
7. Ulcerations/Sores
8. Growths
9. Acne
10. Shingles
11. Thick skin or finger nails
12. Swollen or puffy skin

Cardio-Vascular

1. High blood pressure
2. Low blood pressure
3. Rapid beating heart
4. Slow beating heart
5. Chest pain
6. Hardening of the arteries
7. Poor circulation
8. Varicose veins
9. Stroke
10. Heart attack
11. Pain in left arm
12. Poor wound healing
13. Dry cracked hands/feet/nails

Emotional

1. Depression
2. Nervousness/Anxiety
3. Stress
4. Mood swings
5. History of emotional trauma or abuse
6. History of physical abuse
7. Present emotional or physical abuse
8. Eating disorders
9. Suicidal thoughts
10. Attempted suicide

Endocrine

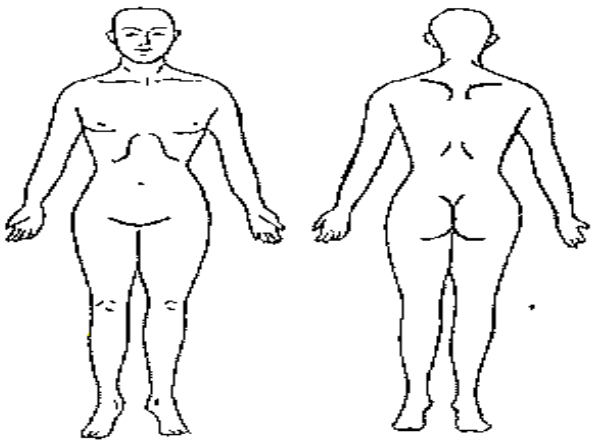
1. Cold hands and feet
2. Excessive hunger
3. Excessive thirst
4. Excessive sweating
5. Night sweats
6. Poor appetite
7. Chronic fatigue
8. Recurrent fevers
9. Always feeling cold/chills
10. Heat intolerance
11. Cold intolerance
12. Loss of weight
13. Weight gain
13. Weight loss

Musculo-Skeletal

1. Leg cramp on walking
2. Weakness in arms/legs
3. Numbness/Tingling
4. Joint pain or stiffness
5. Morning pain or stiffness
6. Gout
7. Sciatica
8. Swelling of hands/feet
9. Difficulty standing/sitting
10. Pain bending forward/back
11. Posture problems
12. Tremors
13. Sprained ankles
14. Broken bones

Indicate on diagram any problem areas:

Please circle any areas of pain, numbness or tingling:



Female Only

1. Age menses began _____
2. Length of period (i.e. 5 days) _____
3. Length of cycle (i.e. 28 days) _____
4. Are cycles regular? **Yes** **No**
5. Date of last PAP? _____
6. Date of last menstrual period? _____
7. Number of pregnancies _____
8. Number of live births _____
9. Number of miscarriages _____
10. Number of abortions _____
11. Are you sexually active? **Yes** **No**
12. Birth control? **Yes** **No**
13. What type? _____
14. Do you self examine your breasts? **Yes** **No**
15. Is it possible that you could be pregnant? **Yes** **No**
16. Sexual drive/libido **High** **Med** **Low**
17. Pain during intercourse
18. Sexual difficulties
19. Menstrual cramps
20. Bleeding between periods
21. Excessive bleeding
22. Scanty bleeding
23. Clots
24. Premenstrual Syndrome
25. Vaginal discharge/itching
26. Vaginal dryness
27. Difficulty conceiving
28. Menopausal symptoms
29. Hysterectomy
30. Sexually transmitted disease
31. Abnormal PAP

Male Only

1. Are you sexually active? **Yes** **No**
2. Birth control? **Yes** **No**
3. What type? _____
4. Sexual drive/libido **High** **Med** **Low**
5. Erectile difficulty
6. Sexual difficulties
7. Penile pain
8. Penile discharge
9. Testicular pain
10. Testicular masses
11. Hernia
12. Genital sores
13. Difficulty starting or stopping urination
14. Enlarged prostate
15. Sexually transmitted disease

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MANDATORY DISCLOSURE FORM

Please read the following disclosure form required by the State of Colorado Department of Regulatory Agencies and sign on the line provided at the bottom of the 2nd page.
Thank You.

- **Education**

	Date	**Degree**
University of Colorado, Boulder, CO	'84-'89	BA
Bastyr University, Seattle, WA	'94-'99	ND, MSA
Brenneke School of Massage, Seattle, WA	'95	LMT
Upledger Institute, Cranio-Sacral	'99	Certified
National College of Naturopathic Medicine	'00	Residency
The Mystery School, Louisville, CO	'02-'05	Certified
-Medical Intuition, Reiki, Theta Healing		

- **Memberships**
  AANP – *American Association of Naturopathic Physicians* since 1994
  CANP – *Colorado Association of Naturopathic Physicians* since 2001
  NCCAOM – *National Certification Commission for Acupuncture and Oriental Medicine,* awarded Diplomate in Acupuncture in 1999.
  AAC – *Acupuncture Association of Colorado* since 2002
  IONS – *Institute of Noetic Sciences* since 1986

- **Work Experience**
  Bastyr University Natural Health Clinic, Seattle, Washington '95 - '99
  North Hawaii Community Hospital, Waimea, the Big Island, Hawaii '99 - '01
  Ho'o Lokahi Integrated Healthcare Center, Kailua-Kona, the Big Island, Hawaii '99 – '01
  Longmont Healing Arts Clinic, Longmont, Colorado '02 - present

- **Licenses**
  Department of Health, State of Hawaii
  - Licensed Naturopathic Physician
  - Licensed Acupuncturist

  Department of Health, State of Washington
  - Licensed Naturopathic Physician #1079
  - Licensed Acupuncturist

  Department of Regulatory Agencies, State of Colorado
  - Licensed Naturopathic Doctor #61
  - Licensed Acupuncturist #785

  None of the above licenses have ever been suspended or revoked.

- Dr. Vaelli complies with all rules and regulations promulgated by the Department of Health with respect to this article, including those related to the proper cleaning and sterilization of needles used in the practice of acupuncture and the sanitation of acupuncture offices.

- The practice of acupuncture in the state of Colorado is licensed by the Department of Regulatory agencies: **Division of Registrations**
  - 1560 Broadway, Suite 1545 Denver, CO 80202 (303) 894-2464

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- The patient may seek a second opinion from another health care professional or may terminate therapy at any time.
- In a professional relationship, sexual intimacy is never appropriate and should be reported to the Director of the Division of Registrations in the Department of Regulatory Agencies.
- The patient is entitled to receive information about the methods of therapy, the techniques used, and the duration of therapy, if known.
- Dr. Vaelli has training in Naturopathic Medicine, Acupuncture, Western and Chinese botanical medicine, homeopathy, cranio-sacral therapy, physical medicine (which includes bodywork and hydrotherapy), nutritional therapy, auricular therapy (ear acupuncture) and electroacupuncture (the use of a small TENS devise in conjunction with acupuncture.) Dr. Vaelli also has training in Medical Intuition, Reiki and Theta Healing.
- *24 Hour Cancellation Policy:* If you do not show for your appointment or if you cancel less than 24 hours before scheduled appointment, you will be charged in full for your missed appointment.
- *Phone Consultation Policy:* Established patients may call Dr. Vaelli at any time with questions or concerns. The first five minutes are free of charge. After that, you will be charged $1.00 per minute.
- *Treatment Package Policy:* You may purchase treatment packages at a discounted rate. You may discontinue treatment at anytime and receive a full refund minus the cost of treatments previously rendered at the regular rate.
- **Fee Schedule:**

Description	**Duration**	**Fee**
First office visit	1½ hours	$145
Follow-up visit	½ hour	$ 45
Follow-up visit	1 hour	$ 80
Follow-up visit	1½ hour	$108
2 treatments per week	2 X 1 hour	$140
3 treatments per week	3 X 1 hour	$180
Series of 5 treatments	5 X 1 hour	$375
Series of 10 treatments	10X1 hour	$700
Cosmetic Acupuncture	1 hour	$ 95
Cosmetic Package	10 treatments	$800

_____ _____

Patient's signature **Date**

THANK YOU!! I look forward to working with you, Dr. V.