Name: DOB: Date:

Client Information

Colleen Gagliardi, ND LAc CCh
Naturopathy, Acupuncture, Chinese Medicine
Located within Notaro Chiropractic
4754 North French Rd., East Amherst, NY 14051

Patient Name:_____

Date of Birth: _____ Age: _____ Male: _____ Female: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone_____

Email: _____

Occupation: _____ Employer: _____

Insurance Company: _____

Emergency Contact:

Name: _____ Phone #: _____

How did you hear about us? _____

Health History Questionnaire

Major Complaint(s):

- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____

_____

_

Name: DOB: Date:

How do these conditions affect your daily activities?:

What would you like addressed today?

Please describe your symptoms:

Was there a specific event that caused this?

Was the onset sudden or gradual?

Are there specific times or activities when you especially notice that your symptoms are worse?

Is this symptom constant or does it come and go – Please describe:

Problem/pain scale from 1-10 with 10 being the "worst":

How has this symptom changed over time - improved, worsened, stayed the same?

If your complaint is related to pain, please circle all that apply to the nature of the pain:

sharp	stabbing	aching	dull	hot	cold	radiating
electric	tingling	fixed	burning	moving	cramping	other:

What prompts you to specifically come in today?

What makes your symptoms better?		soft pressure	hard pressure	cold	
heat	exercise	rest	medication	supplements	chiropractic
massage	acupuncture	physical therapy			

What makes your symptoms worse?		soft pressure	hard pressure	cold	
Heat	exercise	rest	medication	supplements	chiropractic

Name: DOB: Date:

Massage acupuncture physical therapy

What treatments have you have received for this condition?

What is your secondary chief complaint?

Please describe your symptoms:

Was there a specific event that caused this symptom?

Is this symptom constant or does it come and go – Please describe:

Problem/pain scale from 1-10 with 10 being the "worst":

How has this symptom changed over time - improved, worsened, stayed the same?

Are there specific times or activities when you especially notice that your symptoms are worse?

What makes your symptoms better?

What makes your symptoms worse?

What treatments have you have received for this condition?

Has this issue been medically evaluated in the past? What was the diagnosis?

Medication(s)(Including over the counter medications) you are currently taking:

Drug Name/Dose	Reason	Have been taking Since

Name: DOB: Date:

Supplements (vitamins, herbs, minerals, etc

Supplement Name/Dose	Reason:	Taking Since

Please circle all that you have taken in the past:

anti-anxiety meds antacids antibiotics anticonvulsants antidepressants
antifungals aspirin/ibuprofen asthma inhaler beta blocker
chemotherapy meds cortisone (oral or topical) diabetic meds
diuretics estrogen/progesterone heart medications

high blood pressure meds pain killing meds/muscle relaxers, opioids, analgesic medication

hormone therapy laxatives insulin birth control pills or IUD

radiation exposure - treatment, xrays, CT scans, MRI recreational drugs

sleeping pills thyroid medication tylenol/acetaminophen

heartburn meds ulcer medication

List all hospital stays, surgeries, accidents, motor vehicle accidents, physical traumas or serious illnesses that you have had since birth: At age:

Name: DOB: Date:

Who is your Primary Care Provider?

Are there other providers who you are currently seeing?

When was your last physical exam with your PCP?

When were your last labs done?

Any history of abnormal lab work?

Have you had imaging, MRI, CT, Ultrasound - if so, please list year and reason for imaging:

Please list out any allergies to medications, foods or environmental allergies:

Father's significant health issues:

Mother's significant health issues:

Sister's significant health issues:

Brother's significant health issues:

Children's significant health issues if any:

Last vision exam (year):

Date of last dentist visit: Your blood type (if known):

Overall Wellness:

Name: DOB: Date:

If any of these have been a significant issue for you, please mark P for past or C for current.

Eyes:

Eye pain	Vision problems	Wear glasses/contacts	Red eyes
Dry eyes	Itchy eyes	Watering eyes	Dark circles under eyes
Blurry vision	See floaters	Glaucoma	Cataracts

Strong light at night irritates eyes (v)

Ears:

Ear pain or soreness	Itchy ears	Ear pressure/congestion	Meniere's

Frequent ear infections (currently or as a child) Ear ringing high pitched sound (v)

Ear ringing low pitched sound (v) Hearing loss

Excessive ear wax (e) Can hear heartbeat in ear while head on pillow at night (v)

Nose:

Hay fever-Allergies	Post nasal drip	Sinus pressure	Recurrent sinus infections

Decreased sense of smell or taste (m) Runny nose

Nose congestion only during certain seasons Nose congestion only in some situations

Nose congestion constantly Nose congestion constant, but worse at times

Itchy nose Nose bleeds Other:

Mouth:

History of, or currently have silver fillings		Root canals	Cold sores
Tooth pain	Dental implants	Canker sores	TMJ
Tongue sores	Gum pain	Gum disease	Missing teeth
Gums bleed after brushing teeth		Teeth grinding	Dentures
Silver fillings have been removed	Dry mouth	Cavities	

Cracks at corner of mouth (v)

Throat:

Name: DOB: Date:

Frequent strep infections Hard to swallow (m) Hoarseness (m)

Swollen neck lymph nodes "Feels like a lump in throat" (m) Sore throat

Tightness in throat Itchy mouth or throat

History of anaphylactic reaction (throat closing) Have a prescription/or have used an Epi Pen

Pain in throat Feels like things get stuck in throat Gag easily (m)

Head:

Headaches Migraines Past head injury

Loss of consciousness Dry mouth, eyes or nose (m)

Tension headaches at base of skull (e) Headaches when outside in hot sun (e)

If you suffer from headaches/migraines: please describe typical location:

Lungs:

Shortness of breath Asthma Bronchitis Seasonal allergies

Emphysema Pneumonia COPD Positive TB test

Hard to breathe in sometimes Hard to breath out sometimes

Catch myself sighing a lot Dry cough Cough with mucous

Air not satisfying Smothering feeling Tight chest Chest pain with breathing

Chest pain with movement Chest pain with coughing

Wheezing

Cardiovascular:

Chest pain Varicose veins Heart disease

Aware of heavy or irregular breathing Sleep apnea Air hunger

Yawn frequently Need to open windows in a closed room

Need to use an extra pillow to elevate head at night

Shortness of breath with moderate exertion Ankles swell, especially at the end of the day

Cough at night Face turns red for no reason

Dull pain or tightness in chest that radiates into left arm

Name: DOB: Date:

Heart attack TIA's Blood clots/DVT Enlarged heart or heart failure (v)

Elevated triglycerides Anemia Swelling hands/feet

Stroke Poor circulation Snoring Bleeding disorder

High blood pressure Low blood pressure Elevated cholesterol

Heart palpitations Irregular heartbeat Bleed/bruise easily History of blood transfusion

Pulse is slow (below 65 beats per minute) (v)

Digestive- Upper GI:

Belching or gas within 1 hour of eating meal Heartburn or acid reflux

Bloating shortly after eating Food seems to sit in stomach after eating

Get full fast while eating Vegan diet (no dairy, meat, fish or eggs)

Not hungry in general Bad breath Diet frequently

Frequent tickle in throat, need to cough History of, or current, eating disorder

Have lost taste for meat Sweat has strong odor Stomach upset by taking vitamins

Feel like skipping breakfast frequently Feel better when you don't eat

Sleepy after meals Fingernails chip, peel or break easily

Stomach pain or cramps Diagnosed previously with IBS

Diagnosed previously with an ulcer Chronic diarrhea

Diarrhea shortly after meals Black or tarry stools

Undigested food in stool (other than corn) Abdominal pain in upper abdomen

Crave sweet foods Nausea/vomiting (m) Crave chocolate (m)

Crave fatty or greasy foods (e) Binge eating or uncontrolled urge to eat (s)

Liver/Gallbladder:

Frequent pain between shoulder blades Stomach upset by greasy foods

Nausea Sea, car or airplane sickness/motion sickness History of morning sickness

Light or clay colored stools Dry skin, itchy feet and/or skin peels on feet

Headache that occurs over the eyes Gallbladder attacks in the past

Name: DOB: Date:

Gallbladder removed Bitter taste in mouth esp after eating Become sick when drinking wine

Easily intoxicated Drink more than 3 alcoholic beverages /week

Hangover after drinking alcohol History of drug or alcohol abuse

Recovering alcoholic Long term use of prescription medications

Sensitive to chemicals (perfumes, cleaning solvents, insecticides, exhaust etc)

Had regular exposure to diesel fumes, solvents Sensitive to tobacco smoke

History of hepatitis Born between 1945-1965, not been been screened for Hepatitis C

Pain under right side of rib cage Hemorrhoids or varicose veins

Chronic fatigue or fibromyalgia History of blood transfusion

Small Intestine:

Food allergies/sensitivities or you know that certain foods bother you

If so, which foods?

Abdominal bloating 1-2 hours after eating Specific foods make you tired or bloated

Pulse speeds up after eating Hives Crave bread, sweets or pasta

Alternating constipation/diarrhea Crohn's disease

Wheat or grain sensitivity Dairy sensitivity

Are there foods you feel that you could not give up eating? If so, what?

Feel spacey, unreal or have brain fog Abdominal pain mid abdomen

Large Intestine:

Abdominal pain lower abdomen Rectal itching Coated tongue

Constipation Have taken any antibiotic for more than 10 days on more than 2 occasions

Eating sugar, starch or drinking alcohol makes you feel worse

Stools hard or difficult to pass Feel like you never fully evacuate stool

History of parasites (by testing) Less than one bowel movement per day

Stools are loose and not well formed Diagnosed with IBS or colitis

Diverticulitis Diverticulosis Ulcerative Colitis

Name: DOB: Date:

Blood in stool Mucous in stool Bad breath or strong body odors

Excessive foul smelling gas Painful to press along outer sides of thighs (IT Band)

Significant history of right lower abdominal pain (m)

Date of colonoscopy, if you've had one:

Urinary:

History of bladder or kidney infections Dark circles under eyes

Cloudy, dark or bloody urine Kidney stones

Interstitial Cystitis Blood in urine Urinate more than once per night

Frequently urinate more than once per hour Trouble stopping/starting urine

Burning pain with urination Frequent urination Urgent urination

Urinary Incontinence Smelly urine Crave salty foods

Gynecological:

Hormonal Imbalances Endometriosis Breast Lumps Breast pain

Fibroids Ovarian cysts PCOS Missed cycles

Menopausal symptoms Bleeding between cycles Currently sexually active

Currently using birth control Pain during intercourse Take birth control pills (v)

Diagnosed with bacterial vaginosis in past History of HPV

History of STD Genital herpes Abnormal vaginal discharge

Vaginal soreness/burning Vaginal itch Hot flashes Night sweats

Vaginal dryness Low libido PMS Excess sex drive

Associated with menstrual cycle- cramps Associated with menstrual cycle-headaches

Associated with menstrual cycle-fluid retention Associated with menstrual cycle-chocolate cravings

Associated with menstrual cycle-weight gain Associated with menstrual cycle-irritability/anger

Associated with menstrual cycle-depression Associated with menstrual cycle-fatigue

Heavy menstrual cycles Have concerns regarding fertility:

Are you currently trying to get pregnant?

Name: DOB: Date:

Date of last menstrual cycle: _____

Menstrual cycle usually occurs every _____ days

Menstrual cycle usually lasts for how many days _____

During your heaviest flow, how frequently do you need to change protection? _____

How many days does your heavy flow last? _____

Are your menstrual cycles are regular or irregular?_____

Number of pregnancies?_____

Could be pregnant now?_____

Male:

Erectile Dysfunction | Prostate issues | Dribbling or difficult urination

Low libido | Excess sex drive

Genital itching, pain, burning, discharge, redness or irritation

Musculoskeletal:

Chronic muscle aches and pains (v) | Muscle cramps

Joint Pain | Neck pain | Shoulder pain

Arm pain | Upper back pain | Mid-back pain

Lower back pain | Sciatic pain | Hip pain

Knee pain | Calf pain | Foot pain

Restless legs (v) | Muscle weakness | Muscle jerks or twitching

Muscle stiffness | Tight muscles | Numbness/tingling (v)

Arthritis | Scoliosis | Osteopenia (m)

Osteoporosis (m) | Paralysis | Fibromyalgia

Gout | Parkinson's | Cold hands/feet

Muscle spasms | Muscles feel tired often (e)(v) | History of stress fracture (m)

Carpal Tunnel Syndrome (m) | Shorter than you used to be (m)

Calf, foot or toe cramps while at rest (m) | Feet have a strong odor (m)

Name: DOB: Date:

Aspirin is an effective pain reliever (e) Feel worse, sore after moderate exercise (v)

Loss of muscle tone, heaviness in arms/legs (v)

Endocrine:

Hypothyroid Hyperthyroid Adrenal fatigue

Diabetes Blood sugars > 100 Blood sugar < 80

Excessive thirst Excessive hunger Excessive sweating

Tend to be a night person (a) Dizzy when standing up quickly (a)

Difficulty losing weight Always tired, no matter how much sleep you get

Feel mentally sluggish and dull Lack of motivation Don't like being cold

Chronic constipation Excessive hair loss/coarse heair

Morning headaches, wear off during the day Loss of the lateral 1/3 of eyebrows

Chronic muscle aches and pains Allergic to iodine

Difficulty gaining weight, even with large appetite Nervous, emotional, can't work under pressure

Inward trembling Fast pulse at rest Intolerant to high temperatures

Immune:

Hashimoto's Lupus Rheumatoid arthritis

Connective tissue disease Catch colds/flu easily Chronic sinus infections

Chronic yeast infections Mononucleosis Swollen glands

Chronic Fatigue AIDS/HIV Lyme disease

West Nile Virus EBV/CMV Chronic/frequent infections

History of low Vitamin D status on lab History of positive autoimmune markers on lab

History of cancer

Hair/Skin/Nails:

Rash Eczema Psoriasis Acne Change in mole

Hair loss Dandruff, dry skin (e) Itchy skin Hives

Herpes Weak/chipping nails White spots on nails (m)

Name: DOB: Date:

Cuts heal slowly (m) Tend to form scars/keloids (m)

Sunburn easily or suffer sun poisoning (e) Vulnerable to insect bites (v)

Fragile skin, easily damaged (v) warts (v) Small bumps on back of arms (v)

Neuro:

Seizures Dizziness Fainting

Loss of consciousness from injury Have had a blow to the head in the past

Have had blackouts before Falls/Loss of Balance Poor memory

Learning disability Difficulty with speech Trouble concentrating

Trouble thinking clearly Tremors Hyperactive ADD/ADHD

Mood:

Anxiety (v) Depression (v) Lack of motivation

Sadness History of psychiatric illness Irritability Stress

Worry a lot Have phobias/specific fears Panic attacks

General:

Appetite increased Appetite decreased Insomnia

Unexplained weight gain in past year Unexplained weight loss in past year

Unexplained fatigue Frequent chills/fevers MSG sensitivity (v)

Diet & Lifestyle:

Hunger: Are you hungry for three meals per day? Are you thirsty in general?

If thirsty, which would you prefer - warm, cold or room temperature fluids?

Do you tend to be warmer, colder or about the same body temperature as others in a room?

If you tend to be colder than others – is it 'core cold' or hands and feet cold?

Mood the past few days?

Energy level (0 is no energy, 10 is great energy):

Typical water intake/day:

Have you had acupuncture before? If so, for what?

Name: DOB: Date:

Current use of alcoholic beverages: (circle):
none social drinking more than 2 drinks per most evenings
history of alcohol abuse in past

Tobacco use (circle):
none history of tobacco use currently smoke/chew tobacco use vape/e-cigarette

History of or current recreational drug use:

Amount of daily water intake:

Amount of coffee or tea per day:

Amount of soda per day:

Exercise-amount & type per day/week:

Amount of time per day spent outside in nature:

Number of hours of sleep per night?

Sleep quality (circle all that apply): good it's hard to get to sleep
It's hard to stay asleep I wake frequently and have interrupted sleep
difficulty waking up trouble staying awake I snore I use a CPAP
Have been diagnosed with sleep apnea I stay up later than I should
I get up too early I don't feel like I get enough sleep I'm tired most of the time
Wake up without remembering dreams (v)

Do you feel supported by your current relationships?

Type of work you that you do currently?

Do you work over 50 hours per week?

Types of jobs you've held in the past?

Job satisfaction: please rate 0 – 100

What gives you joy in life - what do you like to do in your free time?

Name: DOB: Date:

Stress level (0 is none, 10 is a lot)

Major stressors?

Environment: If you had to describe the "health" of your current residence and work place, how would you describe each of them? Also include any locations where you might spend a great deal of time:

Any travel outside of the US or Canada? If so where?

Have you served in the armed forces? If so, where?

Any significant exposure to (circle all that apply): lead paint asbestos chemicals

solvents herbicides/pesticides mining house remodeling mold
welding automotive repairs new carpet well water farming
gardening dry cleaning breast implants dental implants/root canals

silver fillings

Any history of a tick bite?

Current weight? If this is not a comfortable weight for you, what is your ideal weight goal?

Please describe what you typically eat for your first meal and beverage of the day and what time?

What is your typical next meal/beverage of the day and usual time?

What is your next typical meal/beverage and time that you eat it?

Do you typically snack? If so what time and what do you snack on?

Do you drink tap water, reverse osmosis, filtered or well water?

Name: DOB: Date:

Do you frequently eat out at restaurants or eat fast food?Do you use artificial sweeteners? This includes sucralose (Splenda), aspartame (equal, nutrisweet), saccharin (sweet n low), xylitol or sorbitol?

When was the last time that you felt well?

Describe your "ideal" wellness state – what you would like to have happen as a result of your visit here today:

What activities "take" your energy - what do you feel drained by?

What activities "give" you energy?

How do your health problems affect your family/friends relationships?

How do your health issues affect your work/work relationships?

What hobbies or activities would you resume if it wasn't for your health issues?

Would you agree that your health is having a negative impact on your life?

How much more energy would you feel if your health issues were resolved (0 none, 10 alot)?

How long in general have you been having health issues?

Describe for me what a day of optimal health would look like for you?

On a scale of 1-10 with 10 being the highest, how committed are you in wanting to rid yourself of these problems and start to feel great?

If below 8, what are your reservations?

What are 5 health goals that you would like to accomplish in the next 4-5 months?

What do you foresee as being any obstacle to you achieving your health goals in the next 4-5 months?

Chinese Medicine Treatment – Dr. Colleen Gagliardi, ND LAc CCH

Acupuncture has been explained to me as a treatment consisting of the insertion of needles through the skin at specific points on the surface of the body (small amounts of electrical current may be applied to the needles). Needles may also be inserted in the external ears (auricular therapy), hands and feet. The purpose of acupuncture has been explained as the alleviation of symptoms or disorders. In our clinic only single-use, disposable, factory-sterilized needles are utilized.

I understand that complications may result from an acupuncture treatment. Among these possible complications are: areas of anesthesia (numbness), fainting, weakness, nausea, hematoma (bruising), infection, pain and discomfort, pneumothorax, and aggravation of present symptoms. Being tired, hungry or stressed can on occasion make the body more sensitive to the acupuncture treatment. Please tell your provider if you have any conditions that may inhibit blood clotting, such as hemophilia, or medications that cause blood thinning such as Coumadin or Warfarin. Please do not walk with bare feet in the treatment room.

Moxa therapy involves the warming application of a lit moxa stick (artemesia herb) near to the skin (but not directly to the skin). This application of heated moxa is to gently warm the skin to alleviate symptoms or disorders. Among the possible complications from the application of moxa may include skin reddening, a small blister, or burn from falling ash. Moxa application should not be used if you have decreased sensation due to nerve damage or numbness in the skin. It should not be used on infants or small children or in people with sensitive skin.

Cupping therapy involves the use of a suction applied to the skin using glass cups. The purpose of cupping is for the alleviation of symptoms or disorders. Possible complications of cupping include marks that appear similar to bruises. These marks (which are common with cupping) can last up to 10 or more days, although the marks left by cupping are usually not painful.

Gua sha therapy involves the use of repeated gentle "scraping" of the skin, generally of the neck and back by a dull tool in order to stimulate circulation and healing of the area. Gua sha may be used for symptoms such as tight muscles and for cold and flu symptoms. Possible complications from gua sha include skin reddening (common), and occasionally minor bruising that is usually gone in 5 days.

Acupuncture, acupressure, Moxa, cupping therapy, gua sha therapy, auricular therapy or Chinese herbs are considered experimental procedures and are not considered a substitute for Western medicine. Therapies and recommendations offered shall not be construed by the client to be a diagnosis of treatment of any disease or injury. We recommend that you consult your physician for any serious conditions and receive at least two medical opinions. It is your right and responsibility for your own body.

Please advise Dr. Colleen if you are pregnant or may be pregnant so she may adjust your treatment accordingly.

Since everyone responds to acupuncture differently, the outcome of the treatment cannot be guaranteed. Some individuals may experience total or partial relief after the first few treatments, while others may notice a steady, gradual improvement over time with treatments. On the rare occasion, some people may notice that their pain temporarily seems to get worse before it gets better.

By voluntarily signing below, I show that I have read or have had read to me, this consent to treatment. I am aware of the risks of acupuncture and the other procedures listed above, and have had the opportunity to ask questions. I intend this consent form to cover the entire course of treatment for both the present condition and for any future conditions for which I seek treatment.

Dr. Colleen Gagliardi, ND LAc CCH is a separate independent business not affiliated with Notaro Chiropractic. Dr. Colleen Gagliardi, ND LAc CCH is a separate business operating within the building space of Notaro Chiropractic and Notaro Chiropractic is not responsible for any liability concerning the treatments or services provided by Dr. Colleen Gagliardi, ND LAc CCH.

_____ _____

Patient or Guardian signature Date

Chinese Medicine Treatment – Dr. Colleen Gagliardi, ND LAc CCH
Located within Notaro Chiropractic
4754 N French Rd., East Amherst, NY 14051

I, THE UNDERSIGNED, DO AFFIRM THAT I HAVE BEEN ADVISED BY COLLEEN GAGLIARDI ND LAC, TO CONSULT A PHYSICIAN REGARDING THE CONDITION OR CONDITIONS FOR WHICH I AM SEEKING ACUPUNCTURE TREATMENT.

_____ _____
(Signature) Date

_____ _____
(Signature) Date

Naturopathy, Acupuncture & Hypnosis

by Dr. Colleen Gagliardi, ND, L.Ac., CCH.

(Located within Notaro Chiropractic)

NOTIFICATION CONSENT:

Dr. Colleen Gagliardi will now be sending reminder texts and calls for your convenience on upcoming appointments as friendly reminders.

Dr. Colleen Gagliardi will also be sending emails monthly for our new monthly promotions on supplies.

*By signing this form, you agree to receive text messages, phone calls and emails regarding appointments and promotions from Dr. Colleen Gagliardi, its management company Chiropractic Office Solutions, agents, contractors, and assignees.

Audio and video recordings may be used at the front desk for quality assurance. The recordings are kept secure and are destroyed pursuant to a routine deletion policy.

Thank you.

Signature:_____

Date:_____