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This is a CONFIDENTIAL questionnaire to help determine the best treatment plan for you

Name____ Date___________________________

Home Address____ City__________________________________

State________ Zip________________ Home Phone__________________________ Work___________________

Occupation_____________________________ Person Responsible for your account____________________________

Emergency Contact_______________________________________ Phone________________________________

Who can we thank for referring you?____

Sex___ M___F Height__________ Weight__________ Birth date______________ Age________

Marital Status ☐ Married ☐ Single ☐ Divorced ☐ Widowed Number of Children____________________________

Previous Acupuncture? ☐ yes ☐ no When?___________________ With Whom_____________________________

Please indicate any significant illnesses you or a blood relative (grandparent, parent, or sibling) have had

Illness	You	Relative	When?	Illness	You	Relative	When?
Cancer	☐	☐	______	Diabetes	☐	☐	______
Hepatitis	☐	☐	______	Heart Disease	☐	☐	______
High blood pressure	☐	☐	______	Seizures	☐	☐	______
Rheumatic Fever	☐	☐	______	Emotional disorders	☐	☐	______
Infectious Disease	☐	☐	______	Tuberculosis	☐	☐	______

Sexually Transmitted disease: ☐ gonorrhea ☐ syphilis ☐ HIV ☐ HPV ☐ chlamydia ☐ herpes Date: ______

Please indicate the use and frequency of the following:

	Yes	No	Amount		Yes	No	Amount		Yes	No	Amount
Coffe/black tea	☐	☐	________	Tobacco	☐	☐	________	Water intake	☐	☐	________
Recreational drugs	☐	☐	________	Alcohol	☐	☐	________	Soda Pop	☐	☐	________

Please check the box if any of the following statements are true:

I have known allergies ☐ I am taking Coumadin / Warfarin ☐

I have a pacemaker ☐ I am taking lithium (Eskalith, Lithobid, Lithonate, Lithotabs) ☐

List any medications and supplements you are currently taking: (continue on the back if needed)

Medicine	Dosage	Reason	How Long	Prescribed by	Date last checkup

For Women

Age of 1st period (menarche)________ Are you pregnant? □Yes □ No # of pregnancies___________________
Age of last period (menopause)______ # of live births______ # of abortions______ # of miscarriages_______________
Number of days between periods_____ Date of last gynecological exam_____________ Pap smear_________________
Number of days of flow_____________ Mammogram________________ Bone density scan________________________
Color of flow______________________ Results____
Clots? □ Yes □ No Color__________ ____
Average number of pads you use per day: 1st day_______ 2nd day_______ 3rd day_______ 4th day_______ +days______
Have you been diagnosed with: □ Fibroids □ Fibrocystic Breasts □ Endometriosis □ Ovarian Cysts □ PID Other_______
Location of Pain: □ Lower abdomen □ Lower back □ Thighs □ Other__________________________
Nature of pain: (please indicate before, during or after menses) Other symptoms related to menses

Cramping______________ Stabbing______________ □ Discharge □ Vaginal dryness □ Headache
Burning________________ Aching_______________ □ Nausea □ Constipation □ Diarrhea
Dull___________________ Bloating______________ □ Swollen breasts □ Mood swings □ Ravenous appetite
Consistent______________ Intermittent____________ □ Poor Appetite □ Hot flashes □ Night sweats
Bearing down sensation___________________________ □ Increased libido □ Decreased libido □ Insomnia

For Men

Date of last prostate check up______________ PSA results____________ Manual prostate exam results____________
Lab results____
Frequency of urination: daytime________ night time________ Color of urine: □ clear □ murky odor:___________
Symptoms related to prostate

□ Prostate problems □ Delayed stream □ Dribbling □ Incontinence □ Retention of urine
□ Rectal dysfunction □ Increased libido □ Decreased libido □ Premature ejaculation □ Impotence
□ Back pain □ Groin pain □ Testicular pain Other___________________________________

Symptom Survey (For Everyone)

The following is a list of symptoms that you may or may not ever experience. Please indicate as follows:
no mark ( ) = never experience **check mark** (√) = sometimes experience **Plus sign** (+) = frequently experience

___ lack of appetite
___ excessive appetite
___ loose stool or diarrhea
___ digestive problems, indigestion
___ vomiting
___ belching, burping
___ heartburn/ reflux
___ feeling the retention of food in the stomach
___ tendency to become obsessive in work relationships

___ insomnia, difficulty sleeping
___ heart palpitations
___ cold hands and feet
___ nightmares
___ mentally restless
___ laughing for no apparent reason
___ angina pains

___ abdominal pain
___ chest pain
___ sciatic pain
___ headaches
___ pain pr coldness in the genital area

___ cough
___ shortness of breath
___ decreased sense of smell
___ nasal problems
___ skin problems
___ feeling of claustrophobia
___ bronchitis
___ colitis or diverticultis
___ constipation
___ hemorrhoids
___ recent use of antibiotics

___ eye problems
___ jaundice (yellowish eyes or skin)
___ difficulty digesting oily foods
___ gall stones
___ light colored stool
___ soft or brittle nails
___ easily angered or agitated
___ difficulty in making plans or decisions
___ spasms or twitching of muscles

___ low back pain
___ knee problems
___ hearing impairment
___ ear ringing
___ kidney stones
___ decreased sex drive
___ hair loss
___ urinary problems

___ fatigue
___ edema
___ blood in stool
___ black tarry stool
___ easily bruised
___ difficult stop bleeding
___ asthma
___ tendency to catch colds easily
___ intolerance to weather changes
___ allergies
___ hay fever
___ dizziness
___ tendency faint easily
___ high cholesterol levels
___ sudden weight loss

What are the main health problems for which you are seeking treatment?

____

____

Which other forms of treatment have you sought? ______________________________

____

____

List any other health problems you now have

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List any allergies, food sensitivities or food craving that you have. __________________________

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List any accidents, surgeries, or hospitalizations (include date). __________________________

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Lab Results: (please include copies)__________

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Clinical Notes

How do you FEEL about the following areas of your life? Please check the appropriate boxes and indicate any problems you may be experiencing.

	Great	Good	Fair	Poor	Bad	Your Comments
Significant Other	□	□	□	□	□	______________
Family	□	□	□	□	□	______________
Diet	□	□	□	□	□	______________
Sex	□	□	□	□	□	______________
Self	□	□	□	□	□	______________
Work	□	□	□	□	□	______________
Exercise	□	□	□	□	□	
Spirituality	□	□	□	□	□	

Patient Pain Drawing

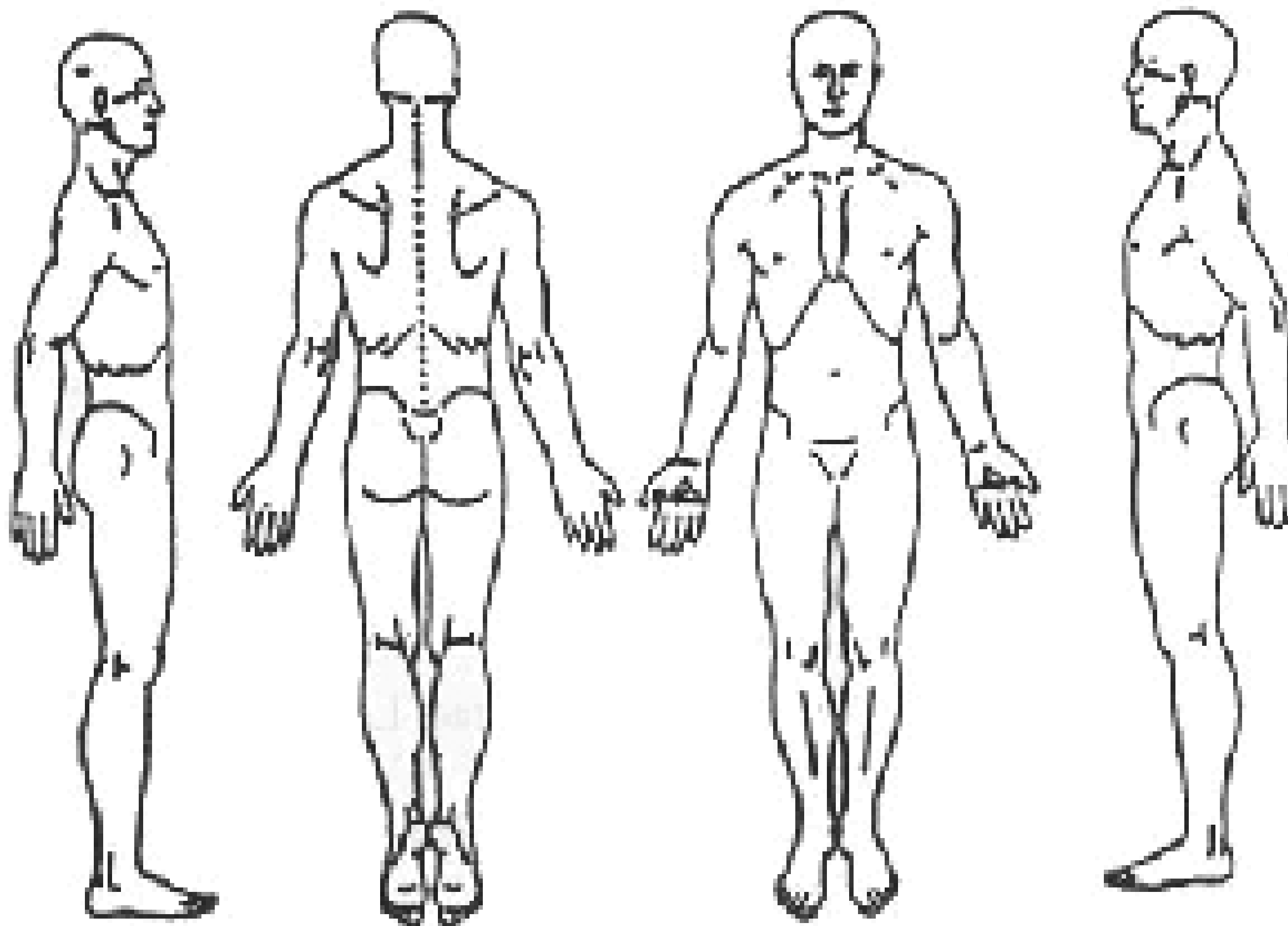
Patient Name____ **Date:**__________________

Mark the areas on your body where you feel the described sensations. Use the appropriate symbol. Include all affected areas.

Ache	Numbness	Pins & needles	Burning	Stabbing
△△△△△	======	OOOOOOO	XXXXXX	///////

Back **Front**

Pain in arms compared to neck
- □ worse than
- □ same as
- □ less than



Pain in leg(s) compared to neck
- □ worse than
- □ same as
- □ less than