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This is a CONFIDENTIAL questionnaire to help us determine the best treatment plan for you. If you have questions, please ask. Thank you.

_________________Today's Date

Last Name ________________________________ First Name ______________________________________

Phone (main) __________________________________ Email _______________________________________

Street _________________________________ City _______________________ Zip __________________

Work phone ____________________________________ Cell# ____

Gender ☐ Male ☐ Female Date of Birth _______________________________ Age _____________

Occupation__________________________________ Employer ____

Emergency contact _____________________________________ Phone _______________________________

Marital status (please circle) Married Single Divorced Widowed # of children ______

Have you received acupuncture therapy before? ☐No

☐Yes Date__________________ Practitioner ____

Check the box if any of the following statements are true:

- ☐ I have known allergies
- ☐ I have a pacemaker
- ☐ I am taking Coumadin/Warfarin
- ☐ I am taking lithium (Eskalith, Lithobid, Lithonate, Littabs)

Please list all medications and supplements you take regularly. **(Continue on back if necessary.)**

Medicine	Dosage	Reason	How long	Prescribed by	Date of last checkup

Please indicate the use and frequency of the following:

	Yes	No	How much?		Yes	No	How much?
Coffee/black tea	☐	☐	________________	Alcohol	☐	☐	________________
Tobacco	☐	☐	________________	Soft drinks (soda)	☐	☐	________________
Non-medical drugs	☐	☐	________________	Water intake	☐	☐	________________

Health History

Confidential

Major complaint/health problem:	
How did this condition develop?	
How long has this condition persisted?	
Please describe anything that makes it better or worse.	
Please describe any treatment you have received for this condition in the past.	
What were the results of the treatment?	
Please list any substances you are allergic to:	

Please list any hospitalizations or surgeries you have had.	Date hospitalization	Surgery

Please describe any significant traumas (car accidents, falls, etc.)	

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

Illness	You	Your relative	Approx Date	Illness	You	Your relative	Approx Date
Cancer	◻	◻		Diabetes	◻	◻	
Hepatitis	◻	◻		Heart disease	◻	◻	
High blood pressure	◻	◻		Seizures	◻	◻	
Rheumatic fever	◻	◻		Emotional disorders	◻	◻	
Infectious diseases	◻	◻		Tuberculosis	◻	◻	

Sexually transmitted diseases ◻ Gonorrhea ◻ Syphilis ◻ AIDS ◻ Chlamydia ◻ HPV ◻ Herpes Date______

Health History

Confidential

Symptoms Check (√) symptoms you currently have or have had in the past year.

General

- ☐ Chills
- ☐ Depression
- ☐ Dizziness
- ☐ Fainting
- ☐ Fever
- ☐ Fatigue
- ☐ Forgetfulness
- ☐ Headache
- ☐ Loss of sleep
- ☐ Sudden loss weight
- ☐ Nervousness
- ☐ Numbness
- ☐ Sweats
- ☐ Hair loss
- ☐ Easily angered/ agitated
- ☐ Tendency to become obsessed in work, relationships
- ☐ Recent use of antibiotics
- ☐ Shortness of breath

Gastrointestinal

- ☐ Appetite poor
- ☐ Bloating
- ☐ Bowel changes
- ☐ Loose stool
- ☐ Bloody stool
- ☐ Black tarry stool
- ☐ Digestive problems
- ☐ Constipation
- ☐ Feeling the retention of food in the stomach
- ☐ Diarrhea
- ☐ Belching/burping
- ☐ Excessive hunger
- ☐ Gas
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Nausea
- ☐ Rectal Bleeding
- ☐ Stomach Pain
- ☐ Heart burn/reflux
- ☐ Vomiting
- ☐ Vomiting blood

Eye, Ear, Nose & Throat

- ☐ Bleeding gums
- ☐ Blurred vision
- ☐ Crossed eyes
- ☐ Difficulty swallowing
- ☐ Double vision
- ☐ Earache
- ☐ Ear discharge
- ☐ Hay fever
- ☐ Hoarseness
- ☐ Loss of hearing
- ☐ Nosebleeds
- ☐ Persistent cough
- ☐ Ringing in the ears
- ☐ Sinus problems
- ☐ Vision - Flashes
- ☐ Vision – Halos
- ☐

Cardiovascular

- ☐ Chest pain
- ☐ Angina problems
- ☐ High blood pressure
- ☐ Irregular heart beat
- ☐ Poor circulation
- ☐ Rapid heart beat
- ☐ Low blood pressure
- ☐ Swelling of the ankles
- ☐ Varicose veins
- ☐ Cold hands and feet

Muscle/Joint/Bone

Pain, weakness, numbness in:

- ☐ Arms
- ☐ Hips
- ☐ Back
- ☐ Legs
- ☐ Feet
- ☐ Neck
- ☐ Hands
- ☐ Shoulder
- ☐ Knees

Skin

- ☐ Hives
- ☐ Itching
- ☐ Change in moles
- ☐ Rash
- ☐ Scars
- ☐ Sores that won't heal
- ☐ Easily bruised

Genito-Urinary

- ☐ Blood in urine
- ☐ Frequent urination
- ☐ Lack of bladder control
- ☐ Painful urination

MEN only

Date of last prostate checkup________ PSA results____________ Manual prostate exam results________________

Lab results____

Frequency of urination Daytime_____ Nighttime_____ Color of urine ☐ Clear ☐ Murky

Symptoms related to prostate:

☐ Prostate problems ☐ Rectal dysfunction ☐ Back pain ☐ Delayed stream

☐ Increased libido ☐ Groin pain ☐ Dribbling ☐ Decreased libido

☐ Testicular pain ☐ Incontinence ☐ Retention of urine ☐ Impotence

☐ Other

WOMEN only

Date of last gynecological exam __________________ Pap Smear_________________ Mammogram __________________

Bone density scan________ Results:____

Are you pregnant? ☐ yes ☐ no Age of 1st period ________ Date of last Menstrual period_________

# of pregnancies______ # of live births_________ # of abortions _________ # of miscarriages __________

Number of days between periods ________ # of days of flow ______ Color of flow _______________________

Clots? ☐ yes ☐ no Color ________ Avg. # of pads used each day? _____ 1st day _____ 2nd day _____ 3rd day _____ 4th day _____ + days

Have you been diagnosed with: ☐ ovarian cysts ☐ fibroids ☐ PID ☐ fibrocystic breasts ☐ endometriosis ☐ other

Location of pain: ☐ thighs ☐ lower abdomen ☐ lower back ☐ other ___________________________

Nature of pain(please indicate before, during or after menses) cramping ________ stabbing _________ dull _________

consistent________ intermittent________ aching________ bearing down sensation________ bloating____________

Other symptoms related to menses:

☐ discharge ☐ vaginal dryness ☐ headache ☐ nausea ☐ constipation

☐ diarrhea ☐ swollen breasts ☐ mood swings ☐ ravenous appetite ☐ poor appetite

☐ hot flashes ☐ night sweats ☐ increased libido ☐ decreased libido ☐ insomnia

Conditions Check (√) conditions you have or have had in the past.

☐ AIDS	☐ Chemical Dependency	☐ High cholesterol	☐ Prostate problem
☐ Alcoholism	☐ Chicken pox	☐ Gall stones	☐ Psychiatric care
☐ Anemia	☐ Diabetes	☐ Kidney disease	☐ Rheumatic fever
☐ Anorexia	☐ Emphysema	☐ Liver disease	☐ Scarlet fever
☐ Appendicitis	☐ Epilepsy	☐ Measles	☐ Stroke
☐ Arthritis	☐ Glaucoma	☐ Migraine headaches	☐ Suicide attempt
☐ Asthma	☐ Goiter	☐ Jaundice	☐ Thyroid problems
☐ Bleeding disorders	☐ Gonorrhea	☐ Mononucleosis	☐ Tonsillitis
☐ Breast lump	☐ Gout	☐ Multiple sclerosis	☐ Tuberculosis
☐ Bronchitis	☐ Heart disease	☐ Mumps	☐ Typhoid fever
☐ Bulimia	☐ Hepatitis	☐ Colitis or diverticulitis	☐ Ulcers
☐ Cancer	☐ Hernia	☐ Pneumonia	☐ Vaginal infections
☐ Cataracts	☐ Kidney stones	☐ Polio	☐ Venereal disease

Diet and health habits

Please give a general idea of your daily diet.

Breakfast	
Lunch	
Dinner	
Snacks	

Do you eat regular meals? ¨ yes ¨ no Are you hungry between meals? ¨ yes ¨ no

Are you sleepy after meals? ¨ yes ¨ no

Do you crave sweets and/or carbohydrates? ¨ yes ¨ no Other food cravings: ______________________________

Please list the approximate times or your meals: ____

Do you exercise? ¨ yes ¨ no Type of exercise: ____

How many times per week? __________________________

Do you enjoy your work? ¨ yes ¨ no

Please list any occupational hazards you encounter such as long work hours, high stress, chemical exposure, or heavy lifting. ____

Please list any other concerns.____