

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

**PERSONAL INFORMATION**

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Gender \_\_\_\_\_  
 Date of Birth (MM/DD/YY) \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_ Home  
 Address \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Phone Number \_\_\_\_\_ Email \_\_\_\_\_  
 Emergency Contact Name: \_\_\_\_\_ Phone(\_\_\_\_\_) \_\_\_\_\_  
 Marital Status \_\_\_\_\_ Number of children \_\_\_\_\_  
 Occupation: \_\_\_\_\_

Have you received acupuncture therapy before?  
 If yes, when \_\_\_\_\_

**MEDICAL HISTORY**

Please indicate any significant illnesses you or a blood relative (Grandparent, parent or sibling) has:

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Please list the Medications you are taking, including supplements, vitamins and herbs.

Medicine	Dosage	Reason	How long	Prescribed by

Check the boxes 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)

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

What other forms of treatment have you sought?

List any other health problems you now have.

List any allergies or food/environmental sensitivities that you have.

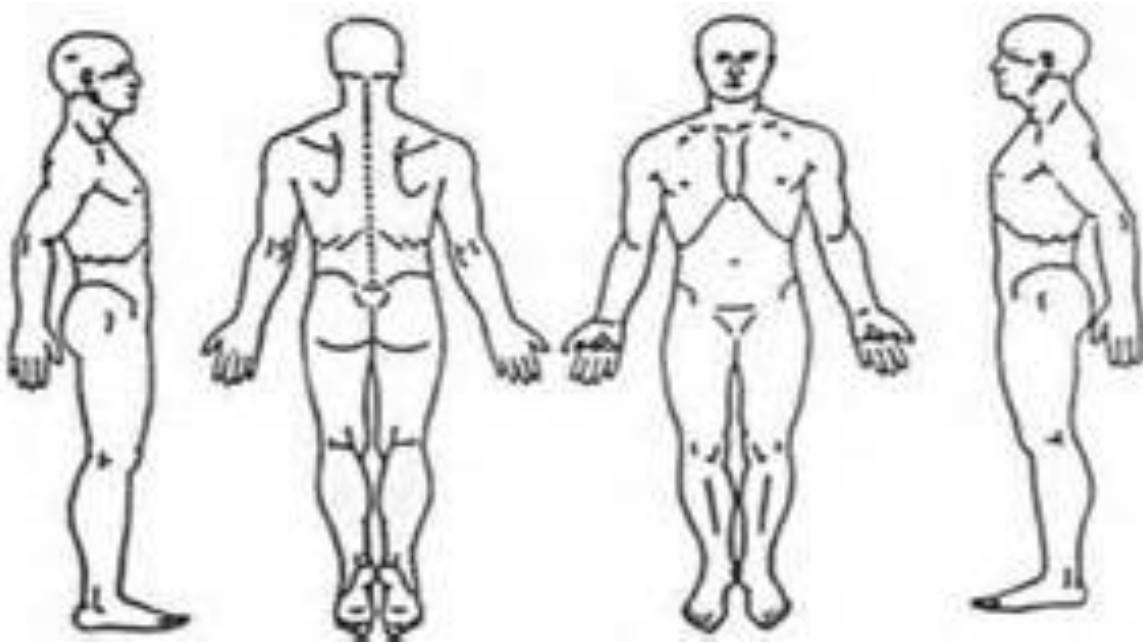
List any accidents, surgeries, or hospitalizations (include date).

Lab results (please provide us with a copy).

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		Comment
Significant Other						
Family						
Diet						
Sex						
Self						
Work						
Exercise						

**MARK AREAS OF CONCERN:**



**SURVEY OF SYMPTOMS**

Please indicate which of the following conditions or symptoms you have experienced within the last 6 months.

**SKIN AND HAIR**

- |                                   |                                    |   |
|-----------------------------------|------------------------------------|---|
| <input type="checkbox"/> Rashes   | <input type="checkbox"/> Eczema    | <input type="checkbox"/> Ulcerations    |
| <input type="checkbox"/> Acne     | <input type="checkbox"/> Itching   | <input type="checkbox"/> Hair Loss      |
| <input type="checkbox"/> Dandruff | <input type="checkbox"/> New Moles | <input type="checkbox"/> Pigment change |

Other skin or hair conditions:

**HEAD, EYES, EARS, NOSE, MOUTH AND THROAT**

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Dizziness          | <input type="checkbox"/> Migraine       | <input type="checkbox"/> Headache(Located: _____) |
| <input type="checkbox"/> Concussion         | <input type="checkbox"/> Facial pain    | <input type="checkbox"/> Cataract                 |
| <input type="checkbox"/> Poor vision        | <input type="checkbox"/> Colorblindness | <input type="checkbox"/> Astigmatism              |
| <input type="checkbox"/> Eye Pain           | <input type="checkbox"/> Spots in eyes  | <input type="checkbox"/> Night blindness          |
| <input type="checkbox"/> Earache            | <input type="checkbox"/> Ringing in ear | <input type="checkbox"/> Poor hearing             |
| <input type="checkbox"/> Inability to smell | <input type="checkbox"/> Nosebleeds     | <input type="checkbox"/> Sinus problems           |
| <input type="checkbox"/> Runny nose         | <input type="checkbox"/> Sore throat    | <input type="checkbox"/> Teeth grinding           |
| <input type="checkbox"/> Dental problems    | <input type="checkbox"/> Jaw clicking   | <input type="checkbox"/> Mouth/lip sores          |

Other head, eyes, nose, mouth and throat conditions:

**CARDIOVASCULAR**

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Chest Pain           | <input type="checkbox"/> Low BP           | <input type="checkbox"/> High BP                |
| <input type="checkbox"/> Irregular heartbeat  | <input type="checkbox"/> Fainting         | <input type="checkbox"/> Cold hands and feet    |
| <input type="checkbox"/> Swelling of hands    | <input type="checkbox"/> Swelling of feet | <input type="checkbox"/> Blood clots            |
| <input type="checkbox"/> Bleeding or bruising | <input type="checkbox"/> Anemia           | <input type="checkbox"/> Genetic blood disorder |

Other cardiovascular conditions:

**RESPIRATORY**

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Difficulty breathing | <input type="checkbox"/> Cough              | <input type="checkbox"/> Phlegm (Color ____) |
| <input type="checkbox"/> Asthma               | <input type="checkbox"/> Pain on inhalation | <input type="checkbox"/> Bronchitis          |
| <input type="checkbox"/> Pneumonia            | <input type="checkbox"/> Wheezing           |  |

Other respiratory conditions:

**DIGESTIVE**

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Poor appetite   | <input type="checkbox"/> Weight gain   | <input type="checkbox"/> Weight loss    |
| <input type="checkbox"/> Cravings        | <input type="checkbox"/> Strong thirst | <input type="checkbox"/> Nausea         |
| <input type="checkbox"/> Vomiting        | <input type="checkbox"/> Diarrhea      | <input type="checkbox"/> Constipation   |
| <input type="checkbox"/> Gas / Bloating  | <input type="checkbox"/> Belching      | <input type="checkbox"/> Black stools   |
| <input type="checkbox"/> Blood in stools | <input type="checkbox"/> Indigestion   | <input type="checkbox"/> Bad breath     |
| <input type="checkbox"/> Hemorrhoids     | <input type="checkbox"/> Rectal pain   | <input type="checkbox"/> Abdominal pain |
| <input type="checkbox"/> Gallstones      |  |   |

Other digestive or gastrointestinal conditions:

**UROGENITAL**

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Pain on urination  | <input type="checkbox"/> Urgency to urinate    | <input type="checkbox"/> Difficulty urinating |
| <input type="checkbox"/> Frequent urination | <input type="checkbox"/> Unable to hold urine  | <input type="checkbox"/> Impotence            |
| <input type="checkbox"/> Blood in urine     | <input type="checkbox"/> Kidney stones         | <input type="checkbox"/> Sores on genitals    |
| <input type="checkbox"/> Discharge (Color)  | <input type="checkbox"/> Pain with intercourse | <input type="checkbox"/> Genital pain         |

What color is your first urine in the morning?

Other urogenital conditions:

**MEN ONLY**

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Hernias          | <input type="checkbox"/> Testicular masses    | <input type="checkbox"/> Testicular pain       |
| <input type="checkbox"/> Prostate problem | <input type="checkbox"/> Erectile dysfunction | <input type="checkbox"/> Premature ejaculation |

Date and results of last prostate exam:

**GYNECOLOGICAL**

Age at first menses \_\_\_\_\_ Age at menopause \_\_\_\_\_

Are you pregnant? (Yes / No)

# of live births \_\_\_\_\_ # of abortions \_\_\_\_\_ # of miscarriages \_\_\_\_\_

Length of cycle \_\_\_\_\_ Duration of bleeding \_\_\_\_\_ 1st day of last period \_\_\_\_\_

Do you use birth control? If so, what type and for how long?

What color is your menstrual flow?

Is there pain accompanying your menstruation? Before, during or after?

Nature of menstrual pain:

Cramping  Stabbing  Burning  Dull  Bloating  Consistent  Intermittent

Symptoms Related to Menses:

Discharge  Moodswings  Headache  Insomnia  Decreased libido  Increased libido  Constipation  
 Diarrhea  Vaginal dryness  Nightsweats  Hot flashes  Nausea  Poor appetite  Increased appetite  
 Breast lumps  Swollen or tender breasts

When do you feel these symptoms more: before, during or after the menstruation?

Date and results of last gynecological exam/ mamogram:

Other gynecological conditions:

**ENDOCRINAL, NEUROLOGICAL, AND PSYCHOLOGICAL**

_____ Seizures	_____ Fainting	_____ Poor memory
_____ Dizziness	_____ Lack of coordination	_____ Loss of balance
_____ Tingling/numbness	_____ Motor loss or weakness	_____ Tremors
_____ Sweating easily	_____ Temperature imbalance	_____ Thyroid problem
_____ Diabetes	_____ Anxiety	_____ Depression
_____ Easily angered	_____ Mood swings	_____ Hallucinations

Do you feel like harming or killing yourself or someone else at this time? (Yes / No)

Other endocrinal, neurological or psychological conditions: