



**This is a confidential questionnaire to help us determine the best treatment plan for you. If you have any questions, please feel free to ask. Thank you.**

Last First Middle Name \_\_\_\_\_ Date: \_\_\_\_\_  
Address \_\_\_\_\_ S.S. # \_\_\_\_\_  
Email: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Work Phone \_\_\_\_\_  
Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Marital Status M \_\_\_ S \_\_\_ D \_\_\_ W \_\_\_

Biological Sex M/F

If you have a different preferred pronoun outside of your biological sex please describe so we can be sensitive to that \_\_\_\_\_

Occupation \_\_\_\_\_ Employer \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Phone \_\_\_\_\_

Who should we thank for referring to this office? How did you hear about us?  
\_\_\_\_\_

Have you received acupuncture therapy before? Y N  
(date) \_\_\_\_\_ (Acupuncturist) \_\_\_\_\_

What are your main complaints that brought you to this office? Please provide a brief history.

#1 \_\_\_\_\_

#2 \_\_\_\_\_

Do you have any other health conditions that are causing you worry or discomfort?  
\_\_\_\_\_

List all major accidents, surgeries, or hospitalizations (including date or age).  
\_\_\_\_\_  
\_\_\_\_\_

List any medications and supplements you are currently taking (indicating a reason).  
\_\_\_\_\_  
\_\_\_\_\_

Do you have any known allergies, and to what? \_\_\_\_\_  
\_\_\_\_\_

When and where were you last seen by a medical doctor? Name of physician: \_\_\_\_\_

Date: \_\_\_\_\_ Reason for visit: \_\_\_\_\_

Diagnosis \_\_\_\_\_

In your family, have you or anyone else had following diseases? If yes, please indicate the relationship to you. \_\_\_\_\_ Cancer \_\_\_\_\_ Tuberculosis \_\_\_\_\_ Diabetes \_\_\_\_\_ Hypertension \_\_\_\_\_ HIV Positive

\_\_\_\_\_ Hepatitis Do you have any of the following conditions or problems? \_\_\_\_\_ digestion \_\_\_\_\_

constipation \_\_\_\_\_ fatigue \_\_\_\_\_ diarrhea \_\_\_\_\_ dizziness or fainting \_\_\_\_\_ menstruation \_\_\_\_\_ bleed easily \_\_\_\_\_ infectious diseases \_\_\_\_\_ easily anxious or nervous \_\_\_\_\_ high blood pressure \_\_\_\_\_ other \_\_\_\_\_ hypertension \_\_\_\_\_ menstruation \_\_\_\_\_ heart \_\_\_\_\_ urinary tract \_\_\_\_\_ sexually transmitted disease \_\_\_\_\_ high cholesterol

What type of care do you desire? \_\_\_\_\_ temporary relief of symptoms/pain control \_\_\_\_\_ eradication of tendencies causing your condition. \_\_\_\_\_ balanced optimum health-care, elimination of root cause of problem, if possible. \_\_\_\_\_ maintenance care/ balance to stay in good health.

How would you classify your condition? \_\_\_\_\_ minor \_\_\_\_\_ involved severe/worsening \_\_\_\_\_ serious

On a scale of 1-10, how would you rate how your health problem affects your life? (1 is no problem, 10 is major problem) \_\_\_\_\_

What other modalities of care have you tried for this condition? \_\_\_\_\_

Lab results: (please include copies, if available) \_\_\_\_\_

List one adjective/word to describe your life \_\_\_\_\_.

Please indicate the use and frequency of the following?

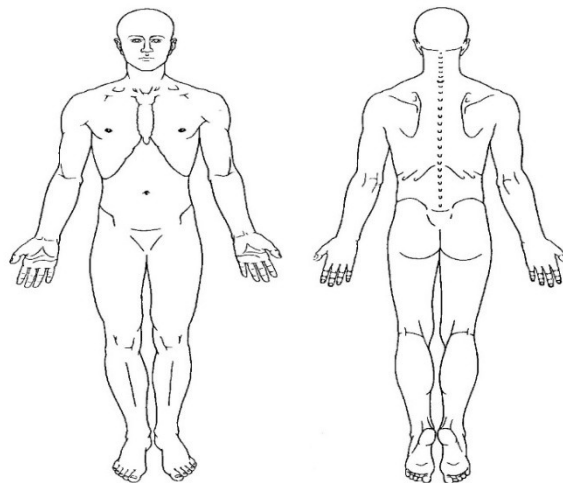
tobacco \_\_\_\_\_ coffee/black tea \_\_\_\_\_ alcohol \_\_\_\_\_

non-prescription drugs \_\_\_\_\_ exercise \_\_\_\_\_

How much water do you drink in a day? \_\_\_\_\_

What temperature is the water that you drink? \_\_\_\_\_

**Place an X on the image below, where you feel pain, numbness or tingling:**



**PATIENT PROFILE (for all patients)**

Put a check mark next to any that apply:

| Water (KD/UB)         | Wood(LV/GB)         | Fire (HT/SI)          | Earth (SP/ST)  | Metal(LU/LI)      |
|-----------------------|---------------------|-----------------------|----------------|-------------------|
| Hearing Loss          | Headaches           | Dry Scalp             | Underweight    | Bronchitis        |
| Dizziness             | Migraines           | Skin Rash             | Overweight     | Asthma            |
| Low Back Pain         | Ringing in Ears     | Cysts/Tumor           | Indigestion    | Cough             |
| Aversion to Cold      | Poor Eyesight       | Ear Infection         | Gassy          | Sinus Issues      |
| Hair Thinning/Loss    | Dry Eyes            | Sore Throat           | Food Allergies | Allergies         |
| Frequent Urination    | Eczema              | Lymph Swelling        | Stomach Aches  | Nose Infection    |
| Kidney Stones         | Shingles            | Hot Palms/Feet        | Ulcers         | Grief             |
| Sweat Easily          | Herpes Simplex      | Heart Palpitations    | Diarrhea       | Frequently Crying |
| Weak Knees/Legs       | Warts               | Aversion to Heat      | Constipation   | Skin Issues       |
| Asthmatic Cough       | Irritability        | Bitter taste in Mouth | Anemia         |                   |
| Rapid Weight Change   | Epilepsy            | Gum Issues            | Bad Breath     | <b>OTHER</b>      |
| Loose Teeth/Loss      | Tremors             | Nose Bleed            | Mouth Sores    | Fatigue           |
| Reduced Sex Drive     | Hepatitis           | Facial Redness        | Heartburn      | Arthritis         |
| Thyroid Issues        | Ulcer               | Itching/Burn Skin     | Low Appetite   | Sciatica          |
| Diabetes              | Vomiting            | Thirst                | Bloating       | Nerve Pain        |
| Frightened Easily     | Gallstones          | Vivid Dreaming        | Excess Worry   | Cold Hands/Feet   |
| Hearing Problems      | Indecisive          | Dark Urine            | Overthinking   | Bursitis          |
| Neck Pain             | Fullness Under Ribs | Night Sweats          | Acid Reflux    | Tendonitis        |
| Sinus Congestion      | Shoulder Tension    | Excess Joy            |                |                   |
| Edema                 | Neck Tension        |                       |                |                   |
| Dark Under Eyes       | Insomnia            |                       |                |                   |
| Emotional Instability |                     |                       |                |                   |

**FOR WOMEN ONLY (check all that apply)**

At what age did your menses begin \_\_\_\_ How many days do you normally bleed? \_\_\_\_

Your bleeding is? Light \_\_\_\_ Normal \_\_\_\_ Heavy \_\_\_\_

Circle All That Apply:

What color is your blood? Bright Red   Red   Dark Red   Purple   Brown   Black

Is there any clotting? YES NO

Are Your Menstrual Cycles Regular? YES NO

Do you spot between cycles? YES NO

Do you have pain with your cycle? YES NO

How many days does the pain last? \_\_\_\_\_

Any breast tenderness? YES NO

Low back pain around cycle? YES NO

Are your bowel movements loose at the beginning of your cycle? YES NO

How many pregnancies have you had?

How many miscarriages have you had?

How many abortions have you had?

How many D&C's have you had?

Have you ever had a cervical biopsy, cauterization or hysteroscopy? \_\_\_\_\_

Do you get yeast infections often? YES NO

Do you have any vaginal discharge? YES NO

If yes, what is the color and consistency? \_\_\_\_\_

Do you feel better after you bleed? YES NO

Do you feel worse after you bleed? YES NO

Do you have any vaginal sores on your genitalia? YES NO

Date of your last Pap Smear? \_\_\_\_\_

Have you ever been diagnosed with uterine fibroids or polyps? YES NO

Have you ever been diagnosed with endometriosis? YES NO

Have you been diagnosed with pelvic adhesions? YES NO

Do your breasts get tender during or around ovulation? YES NO

Do you have pain or cramping during ovulation? YES NO

Have you, or are you currently going through menopause? YES NO

If yes, please list your symptoms?

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

How is your sex drive? LOW HIGH NORMAL

Do you have excessive facial hair? YES NO

Do you have excessively oily skin? YES NO

Have you experienced excessive hair loss on your head? YES NO

Have you been exposed to any known environmental toxins or hormones? YES NO

Have your cycles changed since they began? YES NO

Please describe if yes:

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**FOR MEN ONLY (check all that apply)**

Reduced sexual drive  Pain with urination  Groin pain  Premature ejaculation  Prostate problems  Infertility  Seminal emission  Impotence

Any other comments or concerns:

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**There's a 24-HR Cancellation Policy in effect. If an appointment must be cancelled after a 24 hour period – if not please note the following fees:**

**CANCELLATION OR NO-SHOW FEES:** Cancellations for appointments without a 24-hour notice may be subject to a fee as follows: \$90 for no call/ no show, \$75 if same day cancellation

Fees for treatment do not include any herbs or additional items the Acupuncturist may recommend for you. All fees will be discussed beforehand.

**SIGN:** \_\_\_\_\_

**DATE:** \_\_\_\_\_