

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

Personal Information

Name _____ Date _____
 Home Address _____ City _____
 State _____ Zip _____ Home Phone _____ Work _____
 Cell Phone _____
 Occupation _____ Person responsible for your account _____
 Your Preferred Email _____
 Emergency Contact _____ Phone _____
 How did you hear of us: Website Family Member Friend Acupuncture.com Yelp.com
 Physician/Chiropractor Other _____
 May we thank someone in particular? _____

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 illness you or a blood relative (grandparent, parent, or sibling) have had:

Illness	You	Relative	When?	Illness	You	Relative	When?
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	_____	Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	_____	Seizures	<input type="checkbox"/>	<input type="checkbox"/>	_____
Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	_____	Emotional Disorders	<input type="checkbox"/>	<input type="checkbox"/>	_____
Infectious Diseases	<input type="checkbox"/>	<input type="checkbox"/>	_____	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	_____

Sexually Transmitted Diseases: 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
Coffee/Black Tea	<input type="checkbox"/>	<input type="checkbox"/>	_____	Tobacco	<input type="checkbox"/>	<input type="checkbox"/>	_____	Water	<input type="checkbox"/>	<input type="checkbox"/>	_____
Recreational Drugs	<input type="checkbox"/>	<input type="checkbox"/>	_____	Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	_____	Soda	<input type="checkbox"/>	<input type="checkbox"/>	_____

Please Check the Box if any of the following statements are true:

I have known allergies: Yes No I am taking Coumadin/ Warfarin/ Plavix: Yes No
 I have a pace maker: Yes No I am taking lithium (Eskalith, Lithobid, Lithonate, Lithotabs) Yes No

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: Gynecologic 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 _____
Frist Day of Last Period: _____
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 Insomnia
Consistent _____ Intermittent _____ Poor Appetite Hot flashes Night sweats
Bearing down sensation _____ Ravenous appetite Decreased libido
 Increased libido

For Men

Date of last prostate check up _____ PSA results _____ Manual prostate exam results _____
Lab results _____
Frequency of Urination: daytime _____ nighttime _____ 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 plus sign (+) = frequently experience

__Lack of appetite	__abdominal pain	__eye problems	__fatigue
__excessive appetite	__chest pain	__jaundice	__edema
__loose stool or diarrhea	__sciatic pain	__difficulty digesting oily foods	__blood in stool
__digestive problems, indigestion	__headaches	__gallstones	__black tarry stool
__vomiting	__pain or coldness in the genital area	__light colored stool	__easily bruised
__belching, burping	-----	__soft brittle nails	__difficulty to stop bleeding
__heartburn/reflux	__cough	__easily angered or agitated	__asthma
__feeling the retention of food in the stomach	__shortness of breath	__difficulty in making decisions or plans	__tendency to catch colds easily
__tendency to become obsessive in work, relationships....	__decreased sense of smell	__spasms or twitching of muscles	__intolerance to weather changes
-----	__nasal problems	-----	__allergies
__insomnia, difficulty sleeping	__skin problems	__low back pain	__hay fever
__heart palpitations	__feeling of claustrophobia	__knee problems	__dizziness
__cold hands and feet	__bronchitis	__hearing impairment	__tendency to faint easily
__nightmares	__colitis or diverticulitis	__ear ringing	__high cholesterol levels
__mentally restless	__constipation	__kidney stones	__sudden weight loss
__laughing for no apparent reason	__hemorrhoids	__decreased sex drive	__urinary problems
__angina pains	__recent use of antibiotics	__hair loss	

