Patient Information

Thank you for taking this first step on your healing path. Please THOROUGHLY fill out the following questionnaire to help us determine your best course of treatment. All information you provide is completely confidential.
Thank you for not wearing perfumes, colognes, or smoking before visiting the clinic.

First Name_____ Last Name_____ Today's Date_____/_____/_____

Date of Birth_____/_____/_____ Age_____ Height_____ Weight_____ Gender_____

Address_____ City_____ State_____ Zip_____

Phone we can call to conform your appointment (_____) _____ Other Phone (_____) _____

Email Address_____

Relationship status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Dating ☐ Partnered

Emergency Contact_____ Phone (_____) _____ Relationship_____

Have you previously had acupuncture? ☐ Yes ☐ No When and Where? _____

Primary Health Provider / MD_____ Phone (_____) _____

What is/are the main health concern(s) for which you are seeking treatment?

1._____

How does this condition impact your life? _____

2._____

How does this condition impact your life? _____

Have you received a diagnosis for your condition by a physician? Please describe. _____

_____

What other forms of treatment have you received for your condition? _____

_____

Medical History

Please indicate any illness you or a relative (grandparent, parent, aunt/uncle, sibling) have had. If family history is unknown, please fill out for just yourself:

Condition	Self	Relative	Date Diagnosed	Condition	Self	Relative	Date Diagnosed
Heart disease	☐	☐	_____	Asthma	☐	☐	_____
High Blood Pressure	☐	☐	_____	Cancer	☐	☐	_____
Diabetes	☐	☐	_____	Emotional Disorders	☐	☐	_____
Kidney Disease	☐	☐	_____	Depression/Anxiety	☐	☐	_____
Stroke/Seizures	☐	☐	_____	Bleeding Disorders	☐	☐	_____
Thyroid Disease	☐	☐	_____	Dementia/Alzheimer's	☐	☐	_____

Are you currently under the care of any of the following medical professionals?

☐ Medical Doctor ☐ Chiropractor ☐ Acupuncturist ☐ Physical Therapist
☐ Naturopath ☐ Massage Therapist ☐ Nutritionist ☐ Psychiatrist/Psychologist
☐ Other

Have you had any of the following **immunizations**?

☐ Influenza ☐ Tetanus ☐ Hepatitis B ☐ Measles/Mumps/Rubella
☐ Pertussis ☐ Polio ☐ HBV ☐ Shingles
☐ Other immunizations

Check any of the following that are true:

☐ I am taking Coumadin/Warfarin or other blood thinner ☐ I have surgical implants (screws, plates, drains, etc.)
☐ I am taking Gabapentin ☐ I have a pacemaker

Please list any surgeries, hospitalizations, or accidents you have had:

_____ Date_____
_____ Date_____
_____ Date_____
_____ Date_____

What is your most recent blood pressure reading? _____/_____ When was this taken? _____

Please list any prescribed or over the counter medications, supplements, and vitamins you are currently taking:

_____
_____
_____

Allergies or hyper-sensitivities to medications, foods, insects, chemicals, environments, and your reaction:

_____
_____
_____

For Men

Date of last prostate exam_____ PSA results_____ Urine Color: ☐ Clear ☐ Light Yellow ☐ Dark Yellow
Frequency of Urination: Daytime_____ Nighttime_____ Urine Color: ☐ Brown ☐ Murky ☐ Other_____

Check all that apply:

☐ Prostatitis ☐ Delayed Urine Stream ☐ Incontinence ☐ Urine Retention ☐ Dribbling
☐ Penile Discharge ☐ Premature ejaculation ☐ Increased Libido ☐ Decreased Libido ☐ Impotence
☐ Groin Pain ☐ Testicular Pain/Swelling ☐ Back Pain ☐ Rectal Dysfunction ☐ Other

Have you sought medical intervention for these issues? ☐ Yes ☐ No If yes, what/when? _____

For Women

Age of 1st period (menarche) _____ Are you pregnant? ☐ Yes ☐ No ☐ Unsure

Age of last period (menopause)_____ Are you using/taking birth control? ☐Yes ☐ No What kind/how long? _____

Indicate number of occurrences: Live Births_____ Pregnancies_____ Miscarriages_____ Abortions_____

Date of Last: Gynecologic Exam_____ Pap Smear_____ Mammogram_____ Bone Density Scan_____

Any Abnormal Results? ☐ Yes ☐ No If yes, please explain:_____

Have you been diagnosed with: ☐ Fibroids ☐ Fibrocystic Breasts ☐ PCOS ☐ Endometriosis ☐ Ovarian Cysts ☐ PID

For Women Continued

Date of your last period?_____ Is your menstrual cycle regular? □ Yes □ No Cycle Length:_____ Days of Flow:_____

The flow is: □ Normal □ Heavy □ Light The color is: □ Pale Red □ Bright Red □ Dark Red □ Purple □ Brown

The consistency is: □ Normal □ Thick □ Dilute (watery) Clots? □ Yes □ No Color:_____ Size:_____

Location of Pain: □ Lower Abdomen □ Low Back □ Thighs

Nature of Pain: indicate B (before), D (during), or A (after) period

Cramping_____ Stabbing_____
Dull_____ Aching_____
Bloating_____ Burning_____
Continuous_____ Intermittent_____
Bearing Down Sensation_____

Symptoms Related to Menses/PMS:

□ Swollen Breasts □ Constipation □ Diarrhea
□ Nausea/Vomiting □ Poor Appetite □ Large Appetite
□ Headache □ Migraine □ Mood Swings
□ Vaginal Dryness □ Discharge □ Yeast Infection
□ Hot Flashes □ Night Sweats □ Insomnia
□ Increased Libido □ Low Libido □ Anxiety
□ Bleeding Between Periods (spotting)

Symptom Survey (for everyone)

The following is a list of symptoms you may or may not experience. Please indicate as follows:

No Mark = never experience O = frequently experience X = sometimes experience

Emotional
___Mood swings
___Nervousness
___Anxiety
___Depression
___Stress/Mental tension
___Mental restlessness

Endocrine
___Hyperthyroid
___Diabetes Mellitis
___Hypothyroid
___Hypoglycemia

Energy & Immunity
___Fatigue
___Chronic Infection
___Slow Wound Healing
___Easily Catch Colds

Cardiovascular
___Heart Disease
___High Blood Pressure
___Chest Pain
___Stroke
___Heart Murmur
___Palpitations/Fluttering
___Varicose Veins
___Swelling of Ankles

Respiratory
___Frequent Common Colds
___Shortness of Breath
___Persistent Cough
___Pneumonia
___Difficulty Breathing
___Asthma
___Emphysema
___COPD

Gastrointestinal
___Heartburn
___Epigastric Pain
___Changes in Appetite
___Nausea/Vomiting
___Belching
___Ulcers
___Abdominal Pain
___Passing Gas
___Ulcerative Colitis
___Crohn's Disease

Genito-Urinary
___Painful Urination
___Impaired Urination
___Urinary Urgency
___Frequent Urination
___Kidney Disease
___Kidney Stones
___Blood in Urine

Head, Eye, Ear, Nose, Throat
___Headaches
___Migraine Headaches
___Glasses/Contacts
___Glaucoma
___Impaired Vision
___Eye Pain/Strain
___Eye Tearing/Dryness
___Impaired Hearing
___Earaches
___Ear Ringing
___Sinus Issues
___Allergies/Hay Fever
___Nose Bleeds
___Frequent Sore Throats
___TMJ/Jaw Issues

Neurologic
___Vertigo/Dizziness
___Seizures/Epilepsy
___Numbness/Tingling

Other: ___Cancer ___Liver Disease ___Anemia/Blood Issues ___Skin Issues (hives, rashes, eczema, etc.)

Do you currently have pain in any of the following areas? (check all that apply):
□ Neck □ Shoulder □ Arm □ Upper Back □ Mid Back □ Lower Back □ Leg □ Joint Pain, which?_____

Is the pain: □ Sharp □ Burning □ Aching □ Dull □ Cramping □ Fixed □ Radiating □ Other_____

What makes the pain better or worse? (e.g. heat, pressure, rest, movement, etc.)_____

Is there anything else you'd like to tell us about your health?_____

Lifestyle, Diet, and Nutrition

What is your exercise routine?_____

Do you follow a special diet? ☐ Yes ☐ No If so, please explain:_____

How many meals do you eat per day?_____ Do you prepare meals at home? ☐ Yes ☐ No How often?_____

Drink Preference: ☐ Hot ☐ Room Temperature ☐ Cold Food Preference: ☐ Salty ☐ Spicy ☐ Sweet ☐ Sour ☐ Bitter

Food Cravings:_____ Food Intolerance/Restrictions:_____

Sleep: How many hours per night?_____ ☐ Difficulty falling asleep ☐ Difficulty staying asleep ☐ Difficulty waking up in the A.M.

Do you wake feeling rested? ☐ Yes ☐ No Is your sleep interrupted by anything (partner, pets, noises, etc.)? ☐ Yes ☐ No

Please indicate the use and frequency of the following:

	Yes	No	How Much		Yes	No	How Much		Yes	No	How Much
Coffee/Black Tea	☐	☐	_____	Alcohol	☐	☐	_____	Water intake	☐	☐	_____
Non-medical Drugs	☐	☐	_____	Tobacco	☐	☐	_____	Soda/Pop	☐	☐	_____

Level of Education Completed: ☐ High School ☐ Associate ☐ Bachelors ☐ Masters ☐ Doctorate ☐ Other

Occupation:_____ Hours/Week:_____

Spiritual Practice:_____

Have you experienced any major traumas? ☐ Yes ☐ No Explain:_____

What are you interests and hobbies?_____

How do you feel about the following areas of your life? Please check the appropriate box and include any important commentary.

	Great	Good	Neutral	Fair	Bad	N/A	Comments
Self	☐	☐	☐	☐	☐		_____
Significant Other	☐	☐	☐	☐	☐	☐	_____
Family	☐	☐	☐	☐	☐	☐	_____
Work	☐	☐	☐	☐	☐	☐	_____
Spirituality	☐	☐	☐	☐	☐	☐	_____
Sex Life	☐	☐	☐	☐	☐	☐	_____
Diet/Lifestyle	☐	☐	☐	☐	☐		_____

Dermatology and Facial Rejuvenation Clients Only

Have you seen a dermatologist? ☐ Yes ☐ No If yes, for which condition? _____

Dermatologist Name_____ Phone # _____

Were you prescribed any medications/topicals? ☐ Yes ☐ No Which? _____

What store bought items do you use on your skin?_____

Have you had Botox injections? ☐ Yes ☐ No If yes, how many times? _____ How long ago? _____

Have you had any plastic surgeries or do you have fillers? ☐ Yes ☐ No Which? _____