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This is a confidential questionnaire to determine the best treatment plan for you.

Name_____Age _____ Sex: M / F / Transgender __

Address _____ City _____

State ____ Zip Code _____ Home or Cell Phone _____ Work Phone _____

Email_____Add to email list for occasional announcements? Y / N

Date of birth _____ Height _____ Weight:_____ T oday's date:_____

Occupation:_____ Years:____

I am interested in (check all that apply): □ Acupuncture □ Herb consultation

□ Massage therapy □ Facial renewal (Facial acupuncture) □ Medical Intuitive consultation

Marital Status: Single / Married / Divorced / Separated / Widowed / Dating / In a relationship

Children? Y / N How many? ___ Ages? _____ Referred by

_____

Emergency Contact _____ Phone _____ Relationship _____

Are you currently under the care of a physician? Y / N

Name _____ Number _____ Date of last visit

_____

Have you had acupuncture before? Y / N With whom? _____ When? _____

How did you hear about this clinic? _____

Are you currently taking any medications or supplements? Y / N Please list:

Medication or Supplement	Dosage	Reason	Prescribed by

For which conditions are you seeking treatment? Please list in order of importance to you:

1. _____ 3. _____

2. _____ 4. _____

Please list any accidents, surgeries, or hospitalizations (including dates)

_____

_____

Do you have a pacemaker or other medical implant? Y / N Please explain _____

List any known allergies to food, medication, or inhalants _____

Please indicate the use and frequency of the following:

Water _____ Soda _____ Coffee _____ Tea _____ Alcohol _____

Tobacco _____ Marijuana _____ Recreational drugs _____

Please indicate any illnesses you or a blood relative (parent, grandparent or sibling) have had:

Illness	You	Relative	√ = current	Illness	You	Relative	√ = current
Cancer	□	□		Seizures	□	□	
Hepatitis A / B / C	□	□		Emotional Disorder	□	□	
High Blood Pressure	□	□		Tuberculosis	□	□	
Diabetes Type 1 / 2	□	□		Asthma	□	□	
Heart Disease	□	□		Alcoholism	□	□	

Have you been diagnosed with: □ HIV □ Genital herpes □ Syphilis □ Chlamydia □ Gonorrhea ? Date:_____

Questions for Men

Date of last prostate exam:_____

How many times per night do you awaken to urinate? __ Testicular masses or pain? Y / N

Do you experience any difficulties with urination or sexual activity?
Please Explain:_____

Questions for Women

Do you have a menstrual cycle? Y / N Are you using birth control? Y / N

Is your cycle regular? Y / N Approx. number of days between cycles _ Are you pregnant? Y / N

Number of days of flow _____ Color of flow _____ Any clots? Y / N Color _____

Abortions or miscarriages? Y / N _____Note any of the following related to your cycle:

□ Mood swings □ Cramps □ Breast tenderness □ Spotting between □ Other _____

Have you been diagnosed with: □ Fibroids □ Endometriosis □ Ovarian cysts □ PID Other? _____

Date of Last gynecological exam? _____ Pap Smear? _____ Results? _____

Symptom Survey (all patients)

The following is a list of symptoms you may or may not experience. Please indicate accordingly: No mark = never experience, check mark (√) = sometimes experience, plus sign (+) = frequently experience

_____lack of appetite

____excessive appetite

_____loose stool or diarrhea

_____constipation

_____hemorrhoids

_____excessive thirst

_____acid reflux or indigestion

_____vomiting

_____belching

_____feeling of retention of food in the stomach

_____abdominal pain

_____excessive gas or bloating after meals

_____feeling tired after meals

_____recent use of antibiotics

_____difficulty falling asleep

_____difficulty staying asleep

_____nightmares or vivid dreams

_____morning exhaustion

_____night sweats

_____cold hands and feet

_____subjective cold feelings

_____subjective feeling of warmth

_____memory problems or impaired concentration

_____difficulty making decisions

_____irritable or easily angered

_____tendency to become obsessive over work or relationships

____chest pain

_____heart palpitations

_____shortness of breath or difficulty breathing

_____cough

_____sinus problems

_____headaches

_____eye problems

_____rash or skin problems

_____soft or brittle nails

_____dizziness or vertigo

_____muscle twitching or spasm

_____low back pain

_____knee problems

_____hearing impairment

_____tinnitus / ringing in the ears

_____hair loss / thinning

_____decreased libido

_____edema

____fatigue

_____tendency to catch colds easily

_____sensitivity to damp or cold conditions

_____history of fainting

_____bruising easily

Please list any other symptoms not listed above. Thank you for your answers.

_____

_____

_____