# Acupuncture New Patient Questionnaire

Name _____ Today's Date _____

Address_____City_____

State _____ Zip_____ E-mail address _____

Phone: Home_____ Work_____ Cell_____

Birth date _____ Age _____ Ht _____ Wt _____ Sex M / F

Marital Status _____ No. of Children _____ Occupation_____

Emergency Contact: Name _____Phone _____

Primary Care Practitioner:_____

Is this your first time getting acupuncture? **Y / N** How did you hear about us?_____

**Goals:** What would you most like to achieve with acupuncture treatments?

_____

_____

_____

**Major Symptoms:** Please list in order of importance what symptoms are of concern to you. (most concerning to least, along with the duration of the symptom)

_____

_____

_____

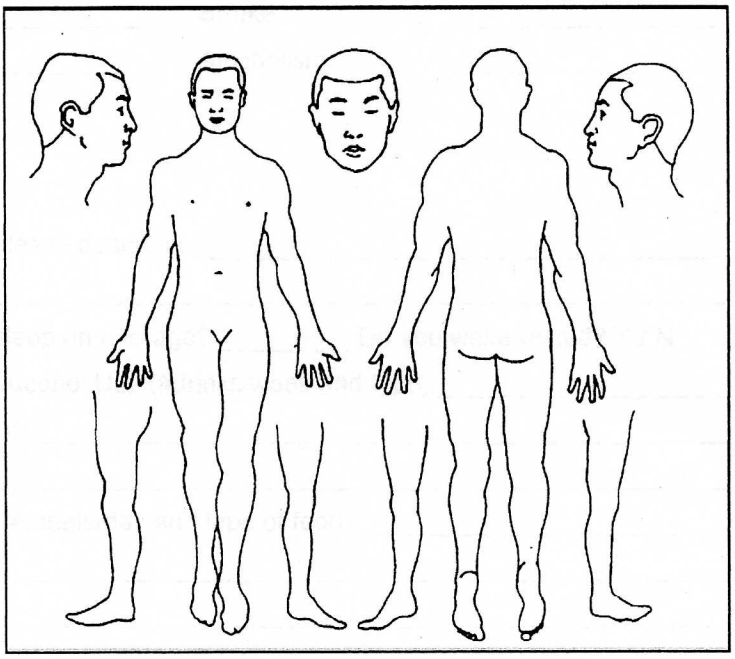
_____

Are you experiencing pain/discomfort in any area of your body? **Y / N**

Please rate your pain level.
1 2 3 4 5 6 7 8 9 10

Use the illustration to indicate painful or distressed areas. Indicate the location of the discomfort by using the symbol that best describes the feeling:

X X X Sharp/Stabbing
P P P Pins & Needles
D D D Dull/Aching
N N N Numbness
T T T Tightness/Spasms



**Medical History**

Do you or have you had any of the following conditions? If yes, please indicate date of diagnosis.

| | Date Diagnosed | | Date Diagnosed |
|---|---|---|---|
| Cancer type:_____ | _____ | HIV | _____ |
| Diabetes | _____ | Mental Illness | _____ |
| Heart Disease | _____ | Seizures | _____ |
| Hepatitis | _____ | Stroke | _____ |
| High Blood Pressure | _____ | Thyroid Disease | _____ |
| High Cholesterol | _____ | Other _____ | _____ |

Please list any surgeries or major injuries with dates.

_____

_____

_____

List any medications or supplements you have taken in the last 2 months.

_____

_____

Do you have a pacemaker or any metal devices in your body? Y / N

**Family History**

Indicate close family members with any of the following.

| | Family member(s) | | Family Member(s) |
|---|---|---|---|
| Cancer (specify type) | _____ | High Cholesterol | _____ |
| Diabetes | _____ | Mental Illness | _____ |
| Heart Disease | _____ | Stroke | _____ |
| High Blood Pressure | _____ | Alcoholism | _____ |

**Lifestyle Habits**

Do you have an exercise routine? Please describe. _____

_____

How many hours per night do you sleep on average? _____ Do you wake rested? Y / N

Nicotine Use: _____ Alcohol Use (#drinks/week and type):_____

Caffeine Use (#drinks/day and type): _____

Water intake (how much/day): _____

Briefly describe your dietary habits (#meals/day and type of food) _____

_____

_____

**Please check all that apply**

**Energy and Immunity**
__ Fatigue
__ Allergies (Specify)_____
__ Anemia
__ Chronic Fatigue Syndrome
__ Thyroid Problems
__ Tendency to Catch Colds

**Head, Eye, Ear, Nose, and Throat**
__ Eye Dryness
__ Blurry Vision
__ Poor Night Vision
__ Ear Ringing
__ Hearing Difficulties
__ Headaches / Migraines
__ Teeth Grinding / TMJ
__ Sore Throat
__ Chronic Sinus Congestion
__ Dry Mouth
__ Bad Breath
__ Mouth Sores / Bleeding Gums
__ Increase in Thirst

**Emotions / Sleep**
__ Mood Swings
__ Anxious / Worried
__ Depressed
__ Irritable
__ Difficulty Making Decisions
__ Stressed
__ Insomnia
__ Nightmares
__ Difficulty Falling or Staying Asleep

**Respiratory/Cardiovascular**
__ Shortness of Breath
__ Asthma
__ Chest Pain
__ Palpitations / Fluttering
__ Poor Circulation (Cold hands/feet)
__ Chronic Cough
__ Night Sweats
__ Unusual Sweating
__ Hot/Cold Intolerance

**Gastrointestinal**
__ Ulcers
__ Changes in Appetite
__ Nausea / Vomiting
__ Bloating / Pain
__ Gas
__ Heartburn / Acid Reflux
__ Belching
__ Hemorrhoids
__ Diarrhea
__ Constipation
__ Sudden Weight Change

**Kidney/Urinary**
__ Painful Urination
__ Frequent Urinary Tract Infections
__ Frequent / Urgent Urination
__ Edema / Swelling

**Musculoskeletal**
__ Neck / Shoulder Pain
__ Muscle Spasms / Cramps / Weakness
__ Arm Pain
__ Finger Pain / Tingling / Numbness
__ Upper Back Pain
__ Mid Back Pain
__ Low Back Pain
__ Leg / Knee Pain
__ Foot / Ankle Pain
__ Hip / Pelvic Pain
__ Arthritis

**Neurological**
__ Vertigo / Dizziness
__ Numbness / Tingling
__ Difficulty Concentrating / Poor Memory

**Skin**
__Rashes / Eczema / Hives / Psoriasis
__ Dry Hair or Hair Loss
__ Changes in Skin Color
__ Easy Bruising
__ Acne
__ Dry / Itchy Skin

**Female Health**
__ Irregular Cycle
__ Heavy Flow
__ Light Flow
__ Clots in Menstrual Blood
__ Menstrual Related Moodiness
__ Menstrual Related Breast Tenderness
__ Menstrual Related Bloating
__ Bleeding Between Cycles
__ Painful Periods (Is pain before, during and/or after period? _____
__ Hot flashes
__ Vaginal Dryness
__ Breast Lumps / Cysts
__ Uterine Fibroids
__ Endometriosis
__ Ovarian Cysts
__ Unusual Vaginal Discharge Odor
__ Frequent Yeast Infections
__ Decreased Libido

**Male Health**
__ Prostate Enlargement
__ Impotence
__ Premature Ejaculation
__ Decreased Libido
__ Groin Pain