

Please complete this questionnaire. Your answers will help us determine how Acupuncture can help you.

NAME _____ **INITIAL VISIT DATE** _____

Address _____ City _____ Postal Code _____

Home Phone # _____ Work Phone # _____

E-mail (H) _____ E-mail (W) _____ Birth Date _____
(DAY/MONTH/YEAR)

Sex M / F Height _____ Weight _____ Family Doctor _____

Occupation _____ Employer _____

How did you hear about our clinic? Y Pgs Internet Referral _____ Other _____

Have you had Acupuncture before? Yes No Dr. _____ Last Visit: _____

Please circle present conditions and check (✓) previous conditions.

GENERAL SYMPTOMS

HEADACHES
MIGRAINES
FEVER
CHILLS
SWEATS
FAINTING
DIZZINESS
SEIZURES
CONVULSIONS
LOSS OF SLEEP
FATIGUE
NERVOUSNESS
LOSS OF WEIGHT
NUMBNESS OR TINGLING IN
ARMS, LEGS OR HANDS
ALLERGIES
WHEEZING
E.E.N.T.
FAILING VISION
NEAR SIGHTED
FAR SIGHTED
EYE PAIN
HEARING LOSS
EARACHE
RINGING IN EARS
NOSEBLEEDS

SORE THROAT
HOARSENESS
ASTHMA
CHRONIC COUGH
FREQUENT COLDS
ENLARGED THYROID
TONSILITIS
SINUS INFECTION
ENLARGED GLANDS
SKIN
ITCHING
RASHES
BRUISING EASILY
VARICOSE VEINS
SENSITIVE SKIN
HIVES
RESPIRATORY
CHRONIC COUGH
SPITTING UP PHLEGM
CHEST PAIN WITH
BREATHING
DIFFICULT BREATHING
CARDIOVASCULAR
RAPID HEART BEAT
SLOW HEART BEAT
HIGH BLOOD PRESSURE

LOW BLOOD PRESSURE
CHEST PAIN ON ACTIVITY
PREVIOUS STROKE
HARDENING OF ARTERIES
SWOLLEN ANKLES
POOR CIRCULATION
MUSCLE & JOINT
NECK ACHE
BACKACHE
SWOLLEN JOINTS
PAINFUL TAILBONE
FOOT PAIN
SHOULDER PAIN
KNEE PAIN
HERNIA
SPINAL CURVATURE
FAULTY POSTURE
ARTHRITIS
GENITOURINARY
FREQUENT URINATION
PAINFUL URINATION
BLOOD IN URINE
KIDNEY INFECTION
KIDNEY STONES
BED WETTING
BLADDER INCONTINANCE

PROSTATE TROUBLE
GASTROINTESTINAL
POOR APPETITE
DIFFICULT DIGESTION
EXCESSIVE HUNGER
BELCHING
HEARTBURN
NAUSEA
VOMITING
STOMACH PAIN
CONSTIPATION
DIARRHEA
FLATULENCE
HEMORRHOIDS
LIVER TROUBLE
GALL BLADDER TROUBLE
JAUNDICE
COLITIS
WOMEN ONLY
PAINFUL MENSTRUATION
EXCESSIVE FLOW
HOT FLASHES
IRREGULAR CYCLE
CRAMPS OR BACKACHE
CONGESTED BREAST
LUMPS IN BREAST

Have you ever had any of the following diseases/conditions?

HYPERTENSION	MUMPS	EPILEPSY	CHICKEN POX	DIPHTHERIA	OSTEOARTHRITIS
HEART DISEASE	MEASLES	DIABETES	SHINGLES	POLIO	RHEUMATOID ARTHRITIS
LUNG DISEASE	RUBELLA	ANEMIA	MONONUCLEOSIS	INFLUENZA	GOUT
CANCER	MALARIA	HYPERTHYROIDISM	VENEREAL DISEASE	SCARLET FEVER	PSORIASIS
STROKE	TUBERCULOSIS	HYPOTHYROIDISM	ALCOHOLISM	RHEUMATIC FEVER	SCOLIOSIS

Other (specify): _____

Has anyone in your family had any of the following conditions/diseases?

HYPERTENSION	DIABETES	SCOLIOSIS	LOW BACK PAIN
HEART DISEASE	TUBERCULOSIS	RHEUMATOID ARTHRITIS	DISC DISEASE
LUNG DISEASE	MULTIPLE SCLEROSIS	ANKYLOSING SPONDYLITIS	SPINAL SURGERY
STROKE	ALZHEIMERS DISEASE	OSTEOARTHRITIS	MIGRAINE HEADACHES
CANCER	GOUT	OSTEOPOROSIS	EPILEPSY

Other (specify): _____

Smoking: Yes No How long? _____ Pregnancy: Yes No How many weeks? _____

Medications/Supplements you currently take: _____

Surgeries you have had in the past: _____