



HEAVEN | EARTH | HUMANITY

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This is a CONFIDENTIAL questionnaire to help us determine the best treatment plan for you.
If you have questions, please ask. Thank you.

Personal Information

Name _____ Date _____
 Home Address _____
 City _____ State _____ Zip _____
 Home Phone _____ Email _____ Work Phone _____
 Cell Phone _____ What is the best way of contacting you? _____
 Occupation _____ Person Responsible for your account _____
 Emergency Contact : Name _____ Phone _____
 Who should we thank for referring you to this office? _____
 Sex : Male Female Height _____ Weight _____ Birth date _____ Age _____
 Marital Status : Married Single Divorced Widowed Significant other
 # of Children _____

Have you received acupuncture therapy before? Yes No
 When? _____ With whom? _____

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

Illness	You	Your Relative	Approx. Date	Illness	You	Your Relative	Approx. Date
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"/>	_____

List any medications and supplements you are currently taking: (Continue on back if necessary.)

Medicine	Dosage	Reason	How long	Prescribed by	Date of last checkup

Supplements	Dosage	Reason	How long	Prescribed by	Date of last checkup

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

- I have known allergies I am taking Coumadin/warfarin
 I have a pacemaker I am taking lithium (Eskalith, Lithobid, Lithonate, Lithotabs)

Any allergies, food sensitivities or food cravings/restrictions (i.e. vegetarian, vegan, Kosher) that you have:

Please indicate any other important information:

List any accidents, surgeries, or hospitalizations: (include dates)

Lab results: (please include copies)

Please indicate the use and frequency of the following:

	Y	N	How much		Y	N	How much		Y	N	How much
Coffee/black tea	<input type="checkbox"/>	<input type="checkbox"/>	_____	Tabacco	<input type="checkbox"/>	<input type="checkbox"/>	_____	Water Intake	<input type="checkbox"/>	<input type="checkbox"/>	_____
Non-medical drugs	<input type="checkbox"/>	<input type="checkbox"/>	_____	Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	_____	Soda	<input type="checkbox"/>	<input type="checkbox"/>	_____

How do you FEEL about the following areas of your life?:

Please check the appropriate boxes and indicate any problems you may be experiencing.

	Great	Good	Fair	Poor	Bad
Significant other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Family	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sex	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Self/Self image	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Work	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Exercise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Spirituality	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Emotions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
LifeStyle	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Your comments

What is your average stress level? (1 is lowest, 10 highest) please circle : 1 2 3 4 5 6 7 8 9 10

What is your average energy level? (1 is lowest, 10 highest) please circle : 1 2 3 4 5 6 7 8 9 10

What time of the day is your energy typically at it's best? _____ it's worst? _____

of hours you get sleep per night: ? _____ time goto bed: ? _____ wake up: _____

Do you sleep well? Y / N (if no, describe) Wake feeling rested? Y / N

Difficulty: Falling asleep / staying asleep / waking up

What are the main health problems for which you are seeking treatment? Please list in order of importance.

- | | |
|----------|----------------------|
| 1. _____ | Date of onset: _____ |
| 2. _____ | Date of onset: _____ |
| 3. _____ | Date of onset: _____ |
| 4. _____ | Date of onset: _____ |

What other forms of treatment have you sought?

Are you under a physician's care for any of your health concerns? (please describe if appropriate):

Please name your Physician and his/her contact information:

Symptom Survey

The following is a list of symptoms that you CURRENTLY may experience. Please indicate as follows:

No mark () =Never experience Check mark (√) = sometimes experience Plus sign (+) = frequently experience

<input type="checkbox"/> Lack of appetite	<input type="checkbox"/> Insomnia	<input type="checkbox"/> Chest oppression	<input type="checkbox"/> Cough
<input type="checkbox"/> Excessive appetite	<input type="checkbox"/> Difficulty falling asleep	<input type="checkbox"/> Abdominal pain	<input type="checkbox"/> Shortness of breath
<input type="checkbox"/> Loose stool or diarrhea	<input type="checkbox"/> Difficulty staying asleep	<input type="checkbox"/> Sciatic pain	<input type="checkbox"/> Decreased sense of smell
<input type="checkbox"/> Digestive problems	<input type="checkbox"/> Nightmares/vivid dreams	<input type="checkbox"/> Neck pain	<input type="checkbox"/> Nasal/Sinus problems
<input type="checkbox"/> Indigestion	<input type="checkbox"/> Somnolence	<input type="checkbox"/> Shoulder pain	<input type="checkbox"/> Skin problems
<input type="checkbox"/> Vomiting	<input type="checkbox"/> Heart palpitations	<input type="checkbox"/> Wrist/carpel pain	<input type="checkbox"/> Bronchitis
<input type="checkbox"/> Belching/Burping	<input type="checkbox"/> Angina/ Chest pains	<input type="checkbox"/> Other pain:	<input type="checkbox"/> Feeling of claustrophobia
<input type="checkbox"/> Heartburn/Reflux	<input type="checkbox"/> Mentally restless	<input type="checkbox"/> Headaches	<input type="checkbox"/> Night sweats
<input type="checkbox"/> Feeling of retention of food	<input type="checkbox"/> Periods of hyperactivity	<input type="checkbox"/> Migraines	<input type="checkbox"/> Colitis/Diverticulitis
<input type="checkbox"/> Constipation	<input type="checkbox"/> Depression	<input type="checkbox"/> Cold hands & feet	<input type="checkbox"/> Hemorrhoids
<input type="checkbox"/> Gas/Bloating	<input type="checkbox"/> Anxiety	<input type="checkbox"/> Cold in genital area	<input type="checkbox"/> Recent use of antibiotics

<input type="checkbox"/> Eye problems	<input type="checkbox"/> Lower Back Pain	<input type="checkbox"/> Black Tarry stools	<input type="checkbox"/> Dissatisfaction
<input type="checkbox"/> Floaters in eyes	<input type="checkbox"/> Knee problems	<input type="checkbox"/> Easily bruised	<input type="checkbox"/> Loneliness/grief
<input type="checkbox"/> Jaundice	<input type="checkbox"/> Hearing impairments	<input type="checkbox"/> Difficulty stopping bleeding	<input type="checkbox"/> Weepiness
<input type="checkbox"/> Difficulty digesting oily foods	<input type="checkbox"/> Ear ringing	<input type="checkbox"/> Tendency to catch colds easily	<input type="checkbox"/> Disconnected
<input type="checkbox"/> Gallstones	<input type="checkbox"/> Kidney stones	<input type="checkbox"/> Intolerance to weather changes	<input type="checkbox"/> Frustration
<input type="checkbox"/> Light colored stools	<input type="checkbox"/> Decreased sex drive	<input type="checkbox"/> Allergies	<input type="checkbox"/> Giddiness
<input type="checkbox"/> Soft or brittle nails	<input type="checkbox"/> Increased sex drive	<input type="checkbox"/> Hay fever	<input type="checkbox"/> Nervousness
<input type="checkbox"/> feeling of something "stuck" in throat	<input type="checkbox"/> Hair loss	<input type="checkbox"/> Dizziness/Vertigo	<input type="checkbox"/> Obsessive: about what?
<input type="checkbox"/> Frequent sighing	<input type="checkbox"/> Fatigue/exhaustion	<input type="checkbox"/> Tendency to faint	<input type="checkbox"/> Indecisiveness
<input type="checkbox"/> Spasms or twitching of muscles	<input type="checkbox"/> Edema	<input type="checkbox"/> Sudden weight loss	<input type="checkbox"/> Fearful
	<input type="checkbox"/> Blood in stools	<input type="checkbox"/> Unusual weight gain	<input type="checkbox"/> Anger or Agitation

For Men

Date of last prostate check up _____ PSA results _____ Manual prostate exam results _____

Lab results _____

Frequency of Urination: daytime _____ nighttime _____ Color of urine: _____ odor: _____

clear murky/cloudy

Symptoms related to prostate and sexual health:

- | | | | | |
|--|---|---|--|---|
| <input type="checkbox"/> prostate problems | <input type="checkbox"/> delayed stream | <input type="checkbox"/> dribbling | <input type="checkbox"/> incontinence | <input type="checkbox"/> retention of urine |
| <input type="checkbox"/> loss of libido | <input type="checkbox"/> increased libido | <input type="checkbox"/> decreased libido | <input type="checkbox"/> premature ejaculation | <input type="checkbox"/> inability to reach ejaculation |
| <input type="checkbox"/> difficulty achieving erection | <input type="checkbox"/> difficulty sustaining erection | <input type="checkbox"/> impotence | <input type="checkbox"/> impaired fertility | <input type="checkbox"/> rectal dysfunction |
| <input type="checkbox"/> back pain | <input type="checkbox"/> hernia | <input type="checkbox"/> testicular pain | <input type="checkbox"/> testicular masses | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Nausea | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Poor appetite | | |
| <input type="checkbox"/> rashes/sores | <input type="checkbox"/> Night sweats | <input type="checkbox"/> Insomnia | Other _____ | |

Are you sexually active? Y / N

What form of birth control are you currently using? _____

Sexually Transmitted Diseases: Gonorrhea Syphilis AIDS HPV Chlamydia Herpes

For how many years? _____

Do you experience any other sexual difficulties? (please describe)

Thank you for taking the time to answer these questions, we appreciate your time & efforts.

I certify that the information I have provided above is correct and accurate to the best of my knowledge.

Patient name

Patient Signature

Date

In the space provided below, please feel free to write down any other signs or symptoms and any other information you would like to mention that have not been covered in the previous pages