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This confidential questionnaire will assist us in designing an individual treatment to best suit you.
Thank you for taking the time to thoroughly fill in each question.

PERSONAL INFORMATION

❑ Ms. ❑ Mrs. ❑ Mr. Name:

Address: Apt #

City: State: Zip:

Home Phone: Alternate Phone:

Email:

Date of Birth: / / Place of Birth:

Any known comlications at birth:

Occupation:

Occupational Stress: ❑ chemical ❑ physical ❑ psychological Other:

How many hours/week do you work? Are you satisfied with your job? ❑ Yes ❑ No

Marital Status: ❑ single ❑ married ❑ divorced ❑ widowed ❑ mutually committed

Have you ever had acupuncture? ❑ Yes ❑ No, when?

For what condition?

Was it a good experience? ❑ Yes ❑ No

How were you referred to us?

Can we contact him/her to thank them for the referral? ❑ Yes ❑ No

GENERAL HEALTH AND TREATMENT HISTORY

What are your reasons/concerns for seeking treatment?

1.-

2.-

3.-

4.-

5.-

When did your health concerns begin?

Your condition is improved by

Your condition is aggravated by

Are you currently under the care of a physician? ❑ Yes ❑ No

For what condition(s)?

Physician's Name: Address:

City: State: Zip:

Phone: Date of last medical doctor visit: / /

What was the reason for your visit to your medical doctor?

Was there a diagnosis offered?

What other methods of therapy (conventional and alternative) have you used for this condition?

Therapy Therapist name Date / /

Response

Therapy Therapist name Date / /

Response

Therapy Therapist name Date / /

Response

Family Health History (please check all that apply to PARENTS/SIBLINGS):

- ❑ Diabetes Who? _____
- ❑ Cancer Who? _____
- ❑ Heart Disease Who? _____
- ❑ Stroke Who? _____
- ❑ High Blood Pressure Who? _____
- ❑ Seizures Who? _____
- ❑ Asthma Who? _____
- ❑ Allergies Who? _____
- ❑ Other _____

Personal Significant illnesses (please check all that apply TO YOU):

- ❑ Allergies To: _____
- ❑ Cancer
- ❑ Diabetes: ❑Type I (insulin usage) ❑Type II
- ❑ Hepatitis: ❑ A ❑ B ❑ C
- ❑ Heart Disease
- ❑ Stroke
- ❑ Seizures
- ❑ HIV / AIDS
- ❑ Pneumonia
- ❑ Tuberculosis
- ❑ Multiple sclerosis
- ❑ Thyroid
- ❑ Asthma
- ❑ Stomach Ulcers
- ❑ Obesity
- ❑ Depression
- ❑ Shingles
- ❑ Chronic Fatigue
- ❑ Rheumatic Fever
- ❑ High Blood Pressure
- ❑ STD's
- ❑ Other _____

Please list any **surgical procedures** you have had:

Surgery	Date
Surgery	Date
Surgery	Date
Surgery	Date

Please list **prescribed** medications you are currently taking and for what condition:

Medication_____Condition_____
Medication_____Condition_____
Medication_____Condition_____
Medication_____Condition_____
Medication_____Condition_____

Please list **over-the-counter** medications you are currently taking and for what condition:

Medication_____Condition_____
Medication_____Condition_____
Medication_____Condition_____
Medication_____Condition_____
Medication_____Condition_____

Please list any **vitamins, supplements, and herbs** you are taking:

Product_____Condition_____
Product_____Condition_____
Product_____Condition_____
Product_____Condition_____
Product_____Condition_____

Please mark in the following table how often do you experience the listed emotions and what is the usual cause that triggers them:

Emotion	Never	Sometimes	Often	Always	Caused by
Happy					
Peaceful					
Anxious					
Relaxed					
Joy					
Anger					
Fear					
Worry					
Depression					
Sadness					

Rate your stress level regarding the following matters.
(Use a 1-10 scale, 0 being no stress, 5 moderate and 10 extremely stressful)

Work	Health	Love	Money	Family	The future	General

DIET, EXERCISE & LIFESTYLE

Do you have a regular exercise program? ❑ Yes ❑ No. Please, describe:

How many meals do you have per day? How many snacks?

Are you or have you ever been on a restricted diet? ❑ Yes ❑ No. What kind?

What foods/flavors do you crave?

Please describe your average daily diet:

Morning	Afternoon	Evening

Dietary preferences:

___ Vegetarian
___ Vegan
___ Raw foods diet
___ Low fat diet
___ High protein/low carb
___ Dairy /milk /cheese
___ Eggs
___ Chicken
___ Fish / seafood
___ Red meat
___ Artificial sweeteners

___ Fast food/ burgers/ fries
___ Spicy / hot
___ Sweet
___ Sour
___ Salty
___ Cold drinks
___ Hot drinks
___Ice chewing
___Extreme thirst
___Thirst with no desire to drink

Do you take any of the following:

Coffee: ❑ Yes ❑ No #____/week ❑ Regular ❑ Decaf
Alcohol: ❑ Yes ❑ No #____/week What? _____
Soda: ❑ Yes ❑ No #____/week ❑ Diet ❑ Regular
Cigarettes: ❑ Yes ❑ No #____/day (Brand:_____)
Recreational Drugs: #____/week (Type:_____)

How is your sleep:

❑ I sleep well.
❑ It's hard to fall sleep
❑ It's hard to stay sleep
❑ I wake up every night at _____
❑ I wake up refreshed
❑ I wake up tired

How many hours/night do you sleep? _____ What time do go to bed? _____

Do you have recurring dreams? ❑ Yes ❑ No. If yes, explain:

_____

_____

Do you use any of the following products?

❑ anti-perspirant
❑ hair dyes/permanents/relaxers
❑ cellular phone, #of mins per day_____
❑ computer, # hours per day_____
❑ commercial household cleaning products

Mark any of the following conditions that applies to you in the present or past:

General conditions

___ Fatigue
___ Sweat without exertion
___ Night sweats
___ Fever / chills
___ Dizziness / vertigo
___ Bleed / bruise easily
___ Low immunity
___ Other _____

Digestion

___ Extreme appetite
___ No appetite
___ Cravings
___ Dieting
___ Tired after eating
___ Bloating
___ Gas
___ Acid regurgitation
___ Heartburn/Ulcers
___ Nausea
___ Vomiting

___ Bulimia
___ Irritability or low energy between meals
___ Other _____

Intestinal
___ Daily Bowel movement
___ Diarrhea
___ Constipation
___ Hemorrhoids
___ Anal itching / burning
___ Laxative use

___ Bloody stool
___ Mucous in stool
___ Contain undigested food
___ Anal fissures
___ Intestinal pain/cramping
___ Incomplete evacuation
___ Hard to push out
___ IBS
___ Colitis
___ Gout
___ Gallstones
___ Other _____

Sleep
___ Fall asleep easily
___ Lie in bed with eyes open
___ Wake at specific times
___ Wake repeatedly
___ Wake frequently to urinate
___ Vivid or Lucid Dreams

___ Wake up not feeling rested
___ Nightmares or frightening dreams
___ Need drugs or supplements to fall asleep

Head, Eyes, Ears, Nose and Throat
___ Dry eyes
___ Spots / flowery vision
___ Blurred vision
___ Poor vision
___ Eye strain
___ Night blindness
___ Cataracts
___ Macular degeneration
___ Bleeding gums
___ TMJ
___ Sores on tongue or mouth
___ Dry mouth
___ Excess saliva
___ Sinus problems
___ Post-nasal drip
___ Sore throat
___ Headaches
___ Swollen glands
___ Difficulty swallowing
___ Earaches
___ Tinnitus / ringing
___ Deafness
___ Nosebleed
___ Other_____

Cardiovascular / respiratory
___ Heart palpitations
___ Chest pain
___ Difficulty breathing
___ High cholesterol
___ Varicose veins
___ Blood clots
___ Swollen ankles
___ Heart valve abnormality
___ Shortness of breath
___ Cold hands / feet
___ Dry cough
___ Wheezing
___ Chest tightness
___ Difficult inhalation
___ Difficult exhalation
___ Productive cough
(color of phlegm?)
___ Other _____

Skin / hair
___ Dry skin
___ Rashes / hives
___ Eczema
___ Psoriasis
___ Pimples / acne
___ Fungal infections
___ Brittle nails
___ Ridged nails
___ Hair loss
___ Dandruff
___ Other _____

Musculoskeletal
___ Spinal pain
___ Joint pain
___ Tendonitis
___ Swelling
___ Arthritis
___ Limited range of motion
___ Vertebral disc degeneration
___ Osteoporosis
___ Numbness
___ Carpal tunnel
___ Other _____

Neuropsychological
___ Anxiety
___ Irritability
___ Insomnia
___ Depression
___ Easily stressed
___ Poor memory

___ Seasonal mood disorder

___ Tics
___ Tremors
___ Death of someone close
___ Job stress
___ Recent divorce
___ Currently in therapy
___ Financial setback
___ Other _____

Genito-urinary
___ Urine Clear
___ Urine Cloudy
___ Urine Dark

___ Painful urination

___ Frequent urination
___ Loss of urine when laughing or sneezing
___ Incomplete urination / retention
___ Dribbling
___ Burning urination
___ Blood in urine
___ Wake frequently to urinate
___ Kidney stones
___ Bedwetting
___ Decreased libido / sexual desire
___ Impotency
___ Infertility
___ Other _____

MEN ONLY

❑ feeling of coldness
❑ numbness in testicles/penis
❑ premature ejaculation
❑ Urinary dribbling
❑ pain or swelling of testicles
❑ impotence/erectile dysfunction
❑ difficulty starting urine flow

WOMEN ONLY

Are you pregnant now? ❑ Yes ❑ No

Number of children _____

Age of menopause_____

Average number of days of flow_____

Does the flow contain:
❑ blood clots ❑ mucous

Age of first period_____

Number of pregnancies_____

Is/was your menstrual cycle regular?
❑ Yes ❑ No
Cycle length: _____ days

The flow is/was:
❑ normal ❑ heavy ❑light

The color is/was ❑ normal ❑ pink
❑ bright red ❑ dark ❑ purple
❑ light brown ❑ dark brown

Do you experience the following:
❑ abdominal cramps ❑ nausea ❑ pms
❑ bleeding between periods
❑ heavy vaginal discharge between periods
❑ breast distention
❑ sadness / moodiness before/during period

Use this template to make a food diary for a week. Include the times of meals.

DATES:							
BREAKFAST							
SNACK							
LUNCH							
SNACK							
DINNER							
CUPS OF WATER							
EXERCISE							
OTHER							