Lifetime Health & Wellness

Acupuncture Patient Questionnaire

Name: _____ Today's Date: _____

Address:_____ City:_____

State: _____ Zip:_____ E-mail address: _____

Phone - Home:_____ Work:_____ Cell:_____

Birth Date: _____ Age:_____ Height: _____ Weight :_____ Sex: M / F

Marital Status: _____ No. of Children: _____ Occupation:_____

Emergency Contact - Name: _____ Phone: _____

Primary Care Practitioner: _____

Is this your first time receiving 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)

_____

_____

_____

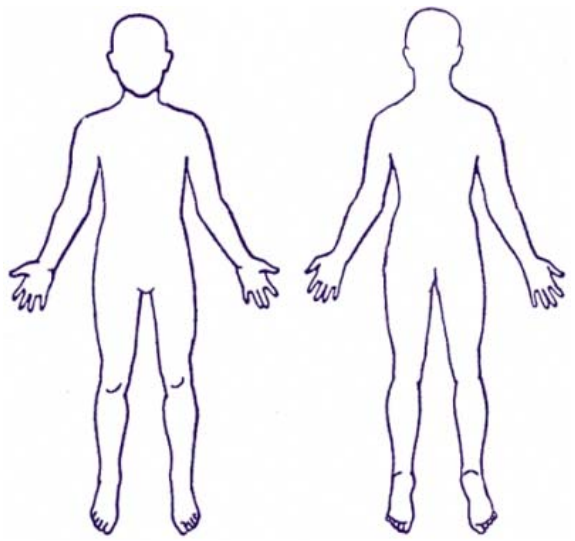
Are you experiencing pain/discomfort in any area of your body? **Y / N**

Please rate your overall pain level:
(1 is low & 10 is high)

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



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Medical History

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

Cancer (specify type):	_____	Hepatitis	_____
HIV	_____	Stroke (specify type)	_____
Diabetes (specify type)	_____	High Blood Pressure	_____
Mental Illness	_____	Thyroid Disease (specify type)	_____
Heart Disease	_____	High Cholesterol	_____
Seizures	_____	Other	_____

Please list any surgeries or major injuries with dates.

_____

_____

_____

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

_____

_____

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

Explain_____

Family History

Indicate close family members with any of the following.

Family member(s) Family Member(s)

Cancer (specify type)	_____
High Cholesterol	_____
Diabetes (specify type)	_____
Mental Illness	_____
Heart Disease	_____
Stroke (specify type)	_____
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) _____

_____

_____

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Please check all that apply

Energy and Immunity
__ Fatigue __ Anemia __ Tendency to Catch Colds
__ Thyroid Problems_____ __ Allergies (Specify) _____

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

Emotions / Sleep
__ Mood Swings __ Anxious / Worried __ Depressed __ Irritable
__ Stressed __ Difficulty Making Decisions __ Insomnia __ Nightmares
__ Difficulty Sleeping (Falling Asleep/Staying Asleep/Waking up throughout night and what times_____)

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

Gastrointestinal
__ Ulcers __ Changes in Appetite __ Nausea / Vomiting __ Bloating / Pain
__ Gas __ Heartburn / Acid Reflux __ Belching __ Hemorrhoids
__ Diarrhea __ Constipation (How often are stools passed_____)
__ Sudden Weight Change

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

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

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

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

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 __ Hot flashes
__ Vaginal Dryness __ Breast Lumps / Cysts __ Uterine Fibroids
__ Endometriosis __ Ovarian Cysts __ Unusual Vaginal Discharge Odor
__ Frequent Yeast Infections __ Decreased Libido
__ Painful Periods (Is pain before, during and/or after period?) _____

Women Only
Pregnant **Y/N** How many weeks? _____
Number of children _____ Number of pregnancies _____
Age of first menstruation _____ Age of menopause _____
Average number of days of flow_____ Average number of days of cycle _____