NEW CLIENT HEALTH QUESTIONNAIRE

All information gathered below is for professional use only and will be held strictly confidential.

GENERAL PATIENT INFORMATION

Patient's Name: _____

Today's Date: _____ DOB: _____ Age: _____

Parent or Guardian (if applicable): _____

Address: _____

Town: _____County_____Postcode: _____

****Email Address(s):** _____

Home Tel: _____Work Tel: _____ Mobile: _____

Married ___ In a Relationship ___ Single ___ Other___ Occupation:

_____

Emergency Contact: _____

Relation to Patient: _____

Contact's Tel: _____

****How were you referred to the clinic?**_____

PLEASE READ THIS IMPORTANT INFORMATION BEFORE YOUR VISIT:

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- Your first appointment will last up to 1 hour. All follow up visits last 45min-1 hour. Always tell me if you need to leave the clinic at a particular time, and I'll make sure you do.
- VERY IMPORTANT! MAKE SURE THAT YOU ARE NOT HUNGRY or overly full when coming in for your treatments. Doing so could result in lightheadedness, nausea or other discomfort during treatment. This is extremely rare and is easily avoided by eating normal, light meals within a few hours of your treatments.
- When you arrive at the clinic, please use the restroom *before* your appointment begins. Even if you don't think you have to. Acupuncture treatments can stimulate your kidneys and bladder, and you definitely don't want to suddenly need to "GO" after all the needles are in place.
- Make sure to wear loose fitting, comfortable clothing to your appointment or bring a change of clothes with you. If I can't reach the areas I need to get to through the clothing you came with, I can provide you with a clean towel to cover up with if necessary.
- After your treatments, you're going to want to relax as much as possible. It's important to give your body a chance to fully-integrate the treatment so don't plan on going to they gym or doing any kind of strenuous exercise when you leave the office. Best case scenario, try to arrange the treatments for when you'll have at least a few hours to go home and relax.

What is the primary reason for your visit today and to what extent does it impair or limit your daily activities?

_____

Other Healthcare Providers or treatments provided for this condition:

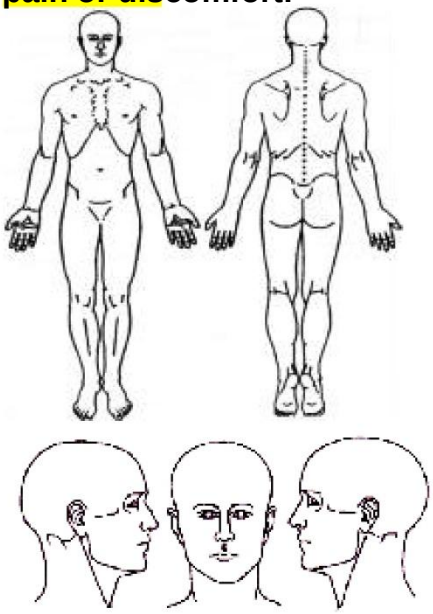
_____

MEDICAL HISTORY

Very important: Do you have any of the following?

Cardiac Pacemaker Seizure Disorder Diabetes (Type ____) Bleeding Disorder
High needle anxiety Low pain thresholdTaking Coumadin/Warfarin/other blood-thinners
Hepatitis or other contagious disease _____ Believe you are or may be pregnant

Please mark areas of pain or discomfort:



On a scale of 1-10, how would you rate the average intensity of pain or discomfort? _____
(1= Slight pain, 10= Extremely intense pain)

Is the pain or discomfort:
Sharp Dull Ache Throbbing Cramping Shooting
Burning Moving Fixed Numbness Tingling
Other: _____

Are the symptoms worse at any particular time of day?

_____

How often do you experience symptoms?

_____

What makes it ***better***? __ Pressure/Massage ___ Cold ___
Heat ____Stillness/Rest ___ Movement/Exercise Other:
_____

What makes it ***worse***? __ Pressure/Massage ___ Cold ___
Heat ____Stillness/Rest ___ Movement/Exercise Other:
_____

History of hospitalizations or surgeries? No Yes If so, please describe, including approximate dates:

_____

_____

History of any Infectious Diseases or Sexually Transmitted Diseases? Yes
If so, please describe, including approximate dates of infection: _____

History of Frequent Antibiotic Use? Yes If so, on average, how many times per year? _____

Do you have any known medication or material allergies or sensitivites? Yes
If so, to what? _____

Please list ALL of your current medications (prescription and over-the-counter):

Name of medication	Prescribed for	Duration of use	Noteable side effects?

List any other herbs, vitamins or nutritional supplements that you are currently taking:

_____

_____

_____

LIFESTYLE

Do you have a regular exercise program? If so, please describe: _____

_____

Vegan/Vegetarian? Yes In the past If so, for how long? _____

Known dietary sensitivities or allergies? **Dairy** **Gluten** **Other** _____

Please describe your average daily diet:

Morning: _____

Afternoon: _____

Evening: _____

Snacks: _____

How much water do you drink per day? _____

Are you a smoker? Yes No In the past If so, for how long? _____yrs Packs/day? _____

Alcohol? # Drinks per week? ____ Type? _____ **Coffee?** Cups per day? ____ Reg or decaf?

Soda? # Sodas per week? ____ Reg or diet? **Caffeinated Tea?** Cups per day? ____ Reg or decaf?

Recreational Drug Use? Yes In the past

Drug(s) _____

HEALTH INVENTORY

❖ Perceived Temperature:

Easily chilled Tendency to feel hot Tendency to feel cold Afternoon fever
Night sweats Hot flashes Cold hands/feet "Always thirsty" Hot sensation in hands, feet or chest

❖ Energy Level & Immunity:

Chronic fatigueAfternoon drowsiness General body weakness Sudden Energy Drops
Fatigue after meals Easily or Frequently catch colds or Flu's Frequent Allergies
Slow wound healing Bruises or bleeds easily Frequent or chronic respiratory or sinus infections
Overall energy level on a scale of 1-10? _____ (1= Extreme Fatigue, 10= High Energy)

❖ Sleep Patterns:

Insomnia Tossing and turning Wakes unrested or groggy in the am Evening Restlessness
Difficulty sleeping _____ nights per week?
Difficulty staying asleep Difficulty falling asleep Wakes to use bathroom ____ times per night
Unpleasant dreams /Nightmares Average # hours sleep/night? _____hrs.
Taking sleep meds? If so, what kind, dose and for how long? _____

❖ Skin & Hair

Dry Skin/Hair Oily Skin/Hair Dry, Cracked Nails Clammy Hands/Feet Frequent skin rashes
Eczema Psoriasis Weak, ridged nails Hives Acne Shortened eyebrows
Female: increased hair growth on face Female: Excessive hair loss or thinning hair

❖ Head, Eyes, Ears, Nose, Throat, Mouth

Dizziness Vertigo Poor vision Blurry vision Cataracts Glaucoma Headaches or Migraines
Spots or "Floaters" in front of eyes Poor night vision Ear ringing ("Tinnitus") Hearing loss
TMJ disorder or teeth clenching/grinding Frequent or Chronic Ear Infections Bitter taste in mouth
Chronic Sinus Pressure or Congestion Sinus Drainage Frequent or Chronic Sinus Infections
Nose bleeds Frequent or recurring canker sores Dry mouth/Throat Toothache

❖ Cardiovascular and Circulatory System

High Blood Pressure Low Blood Pressure High Blood Pressure Blood Clots Lightheadedness
Feeling of heart palpitations FaintingVaricose/Spider Veins Chest Pain/tightness
Irregular or rapid heartbeatHeart Murmer/Mitral Valve Prolapse Poor circulation Pacemaker
Swelling of Hands/Feet History of Heart Attack or Heart Surgery Anemia

❖ Respiratory System

Cough with plegm Cough without plegm Coughing Up Blood Asthma Wheezing
Frequent or Chronic Bronchitis Pneumonia Shortness of breath Chest tightness/heaviness

❖ Gastro-Intestinal System

Irritable, headaches, shaky or lightheaded when hungry Overeating sweets upsets Bad breath
Craves sweets or carbsCraves saltFatty/greasy foods upset digestion Frequent laxative use
Eats breads, pastas, sweets or other carbs frequentlyAcid Reflux/Heartburn Excessive appetite
Poor appetite Frequent Nausea or VomitingConstipation Loose stool Diarrhea (very loose stool)
Feeling of incompletion with BMs Upper Abdominal pain Lower Abdominal Pain Gallstones
Frequent or profuse gas with odor Frequent or profust gas without odor UlcersHemorrhoids
Abdominal Bloating or Fullness Frequent Belching Indigestion soon after eating Light colored stool
How frequently do you have bowel movements?_____

❖ Urinary System

Frequent Urination Urgent Urination Urinary Incontinence Dribbling HesitancyIncomplete
Decreased urine flow Blood in urine Kidney stonesFrequent Urinary Tract Infections
Frequent night urination (# times per night? _____) Other _____

❖ Neurological System

Seizures Tremors Poor Balance Concussion Numbness/tingling Muscle twitching
Lack of Coordination/Balance Other _____

❖ Musculo-Skeletal System

Muscle weakness Muscle cramping/spasms Muscle soreness Muscle tightness Scoliosis
Rheumatoid Arthritis Osteoarthritis Osteoporosis Fibromyalgia Puffiness or Swelling
Limited range of motion Other _____

❖ Psychological/Emotional

How would you rate your overall stress level on a scale of 0-10? _____ *(0= No stress, 10= Extremely high stress)*

Depression Anxiety Anti-depressant medications Panic Attacks "Keyed up" hard to relax
Difficulty making decisions/Apprehension Easily angered or frequent irritability Nervousness
Poor memory or concentration Startles easily Highly emotional Mental Sluggishness
Diagnosed Mental/Emotional Disorder? _____

MEN ONLY:

Feeling of coldness/numbness of genitalia
Testicular pain/redness/swelling
Pain in groin/genitalia
Irregular sperm morphology
Impotence/Erectile Dysfunction
Enlarged Prostate
Poor sperm mobility
Infertility
Low sperm count
Decreased Libido

WOMEN ONLY: Avg. duration of Period: ___ days (Normal is 4-7 days) # Pregnancies _____
Avg. length of Cycle: ___ days (Normal is 24-32 days) # Births _____

Average Menstrual Flow:
Heavy Moderate Light Spotting

Cramps:
None Mild Moderate Severe
Before Period During Period After Period

Clots: None Small Medium Large

PMS? No Yes With emotional upset

Breast Tenderness with period?
Lower Back Pain with period?
Post-Period weakness or fatigue?
Endometriosis?
Irregular Periods?
Bleeding between periods?
Frequent Yeast Infections?
Uterine Fibroids?
Cysts?

Birth control? Yes No In the past
If so, what kind? _____
How long have you been on Birth Control? _____yrs

Menopausal? Yes No
If so, starting at what age? _____

Hot flashes?
With sweating?
Time of day? Morning Afternoon Evening
How intense? Mild Moderate Severe
How many average per day? _____

Night sweats?
Breast lumps?
Vaginal dryness?
Hysterectomy?When? _____
Hormone Replacement Therapy?
Decreased Libido?