classical ACUPUNCTURE

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Please fill out this questionnaire and bring it with you to your first appointment. Some questions may seem unrelated to your condition but they may be useful for your diagnosis and treatment.

HEALTH HISTORY QUESTIONNAIRE

Name _____ Today's Date _____

Age ____ Birthdate _____ Gender: ☐ Male ☐ Female ☐ Non-Binary ☐ Other: _____ Height _____ Weight: _____

Address _____ Phone Number _____

Email _____ Have you ever had acupuncture before? ☐ Yes ☐ No

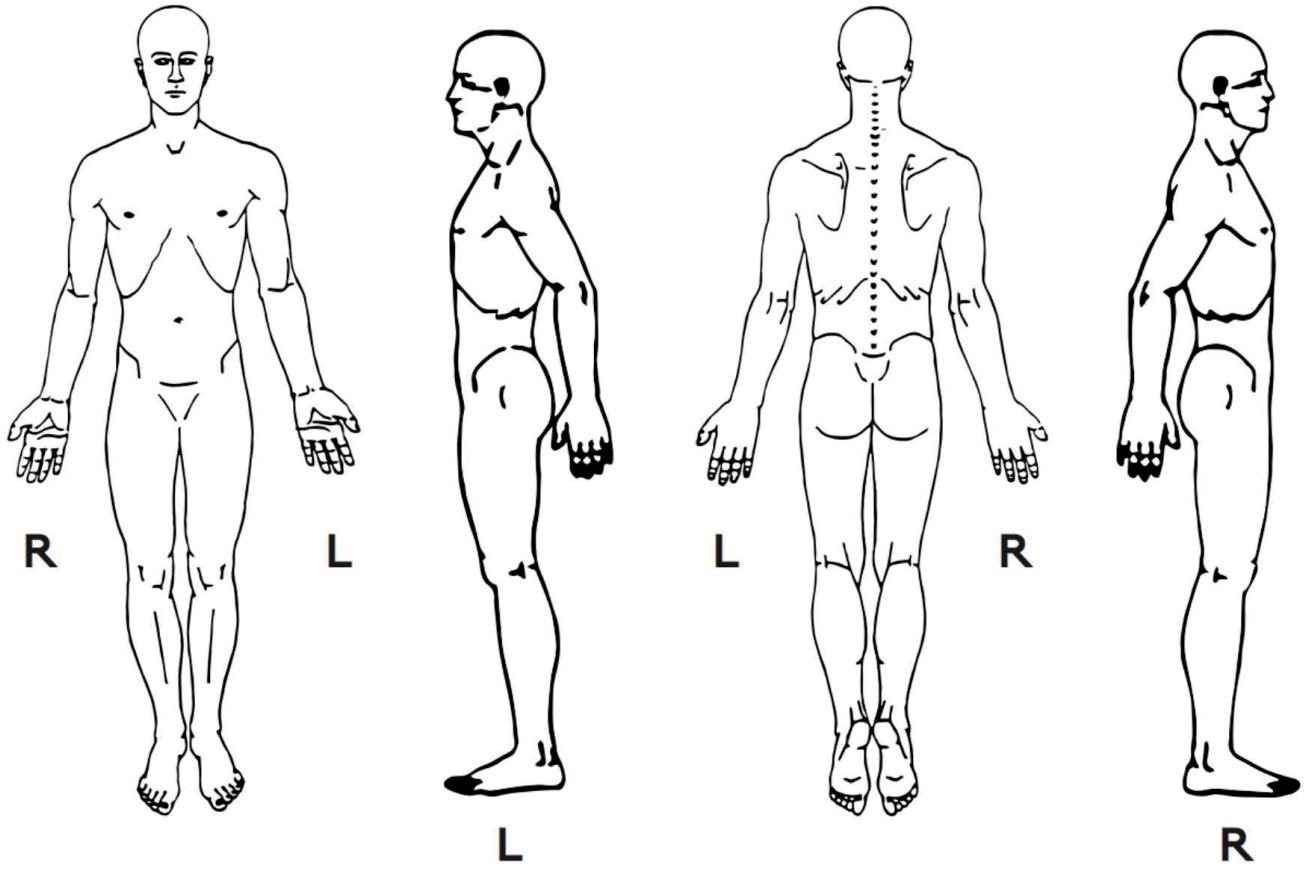
Whom can we thank for referring you? _____ If you were not referred by someone, how did you find out about us? ☐ Online search engine: _____ What search words did you use? _____

☐ List-serve: _____ ☐ Other: _____

CURRENT COMPLAINTS

Please list what you seek acupuncture for. In addition, mark clearly any areas of pain and any scars, even minor ones. Use **P** for pain, **D** for discomfort, **S** for scar, **T** for tightness, **A** for ache.. If you have pain, circle where and indicate the level of pain/discomfort experienced with each one.

Major issues/complaints/reason for visit	**How long have you had this?**	1 = minor discomfort; 10 = excruciating **Level of intensity:**
1. _____	_____	☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10
2. _____	_____	☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10
3. _____	_____	☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10
4. _____	_____	☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10



Is the pain:

☐ Sharp ☐ Dull ☐ Burning ☐ Cramping ☐ Fixed ☐ Moving ☐ Other: _____

Do the following lessen the pain?

☐ Heat ☐ Cold ☐ Pressure ☐ Rest ☐ Movement ☐ Other: _____

Do the following worsen the pain?

☐ Heat ☐ Cold ☐ Pressure ☐ Rest ☐ Movement ☐ Other: _____

Please briefly describe how your major complaints started: _____

_____

Have you previously received treatment for this condition? ☐ Yes ☐ No If yes, when? _____

Where and by whom? _____ What was the diagnosis? _____

What type(s) of treatment(s) were/are being given? _____

Results of treatment(s): _____

_____

EMERGENCY CONTACT/NEXT OF KIN

Name/Relationship/Phone no. _____

_____

PHYSICIAN INFORMATION

Primary care physician(s) with phone no. _____

Specialty care physician(s) with phone no. _____

_____

PATIENT PROFILE

Personal Life:

Occupation and Employer _____ How long? _____

Work stress level _____ How many hours per week? _____

Marital Status: ☐ Single ☐ Married ☐ Partnership ☐ Separated ☐ Divorced ☐ Widowed

Number and ages of any children _____

With whom do you live? ☐ Spouse ☐ Partner ☐ Children ☐ Roommate ☐ Parents ☐ Alone ☐ Pets

Diet and Lifestyle:

Sleep:

When do you usually go to sleep? _____ When do you usually wake up? _____

How many hours to do you need to feel rested? _____ Is your sleep disrupted or disturbed? ☐ Yes ☐ No

Diet:

Are you constantly: ☐ hungry ☐ thirsty Do you crave: ☐ sweets ☐ salty foods ☐ spicy ☐ sour

List any food allergies: _____

Do you currently have or have previously had dietary restrictions? ☐ Yes ☐ No (If so, what kind and when) _____

Are you vegetarian? ☐ Yes ☐ No For how long? _____

What do you usually have for: _____

Breakfast _____ Lunch _____

Dinner _____ Snack _____

Exercise:

Do you exercise: ☐ daily ☐ rarely ☐ regularly ☐ sometimes ☐ never How often? _____

What kind? (eg. walking, yoga, running) _____

How do you feel after exercising? ☐ energized ☐ tired other: _____

CURRENT MEDICATIONS

Medication/Supplement:	Date started:	Dosage:	For what condition?
1.			
2.			
3.			
4.			
5.			

6. Recent vaccinations: _____

7. Allergies to drugs/medications: _____

General Questions:

Do you smoke? ☐Yes ☐No How often?_____ How many a day/week? _____

Do you drink coffee? ☐Yes ☐No No. of cups per day_____ Do you drink alcohol? ☐Yes ☐No No. of drinks per week____

Do you use recreational drugs? ☐Yes ☐No What type/how often? _____

Do you consume artificial sweeteners?: ☐Yes ☐No Do you drink caffeinated tea? ☐Yes ☐No

Please describe your energy throughout the day. What times you are: most energetic _____ and least energetic_____

PAST CONDITIONS

Please check any conditions you have had in the past 5 years.

- ☐ AIDS/HIV
- ☐ Alcoholism
- ☐ Allergies
- ☐ Anemia
- ☐ Appendicitis
- ☐ Asthma
- ☐ Cancer (type:) _____
- ☐ Chronic fatigue
- ☐ Epstein-Barr
- ☐ Heart disease/condition
- ☐ Hepatitis
- ☐ Herpes (oral) (genital)
- ☐ Meniere's
- ☐ Migraines
- ☐ Pneumonia
- ☐ Seizures
- ☐ Shingles
- ☐ STDs
- ☐ Stroke
- ☐ Thyroid disorder
- ☐ Other: _____
- ☐ COVID: date(s) _____

Please list all surgeries you have had:	Date:
1.	
2.	
3.	

Please describe all traumas you have had (falling out of trees, accidents, etc.)	Date:
1.	
2.	
3.	

CURRENT SYMPTOMS

Please check any symptoms you currently have or have had in the past year.

Emotional

- ☐ Happy
- ☐ Easy going
- ☐ Restless
- ☐ Indecisive
- ☐ Cry easily
- ☐ Depressed
- ☐ Stressed out
- ☐ Difficulty expressing emotion
- ☐ Short attention span
- ☐ Anxious

Energy

- ☐ Up and down
- ☐ Low
- ☐ Excessive
- ☐ Fatigue after eating
- ☐ Tired in the afternoon
- ☐ Steady
- ☐ Other: _____

Body Temperature

- ☐ Flushed face
- ☐ Feel warm late afternoon/night
- ☐ Sweat easily
- ☐ Night sweats
- ☐ Chill easily/feel cold/aversion to cold
- ☐ Feel hot/aversion to heat
- ☐ Warm palms/soles
- ☐ Cold hands/feet
- ☐ Normal
- ☐ Other: _____

Appetite
- ☐ Up and down
- ☐ Poor
- ☐ Good
- ☐ Hungry all the time
- ☐ Loss of taste
- ☐ Other: _____

Dizziness/balance
- ☐ Vertigo
- ☐ Dizziness
- ☐ Motion sickness
- ☐ Poor balance
- ☐ Faint easily

Liver & Gall Bladder
- ☐ Anger easily/frustrated/irritable
- ☐ Inability to adapt to stress
- ☐ Numbness: (where?) _____
- ☐ Tight sensation in the chest
- ☐ Chest pain/rib pain
- ☐ Limited range-of-motion (neck)
- ☐ Limited range-of-motion (shoulder)
- ☐ Neck tension
- ☐ Shoulder tension
- ☐ Muscle spasm/cramping/twitching
- ☐ Seizures/convulsions
- ☐ Tingling sensation. Where? _____
- ☐ High-pitched ringing in ears
- ☐ Lump in the throat
- ☐ Bitter taste in the mouth
- ☐ Gallstones
- ☐ Skin rashes (location:) _____
- ☐ STDs: _____

Kidney
- ☐ Cold hands/fingers
- ☐ Cold feet/toes
- ☐ Cold sensation in the knees
- ☐ Sore/weak knees
- ☐ Low back pain
- ☐ Hot flashes any time of the day
- ☐ Heat in the hands, feet, & chest
- ☐ Lack of perspiration
- ☐ Sweaty hands
- ☐ Sweaty feet
- ☐ Startled easily
- ☐ Overall achy feeling in body
- ☐ Low-pitched ringing in ears
- ☐ Memory problems
- ☐ Excessive hair loss
- ☐ Snoring
- ☐ Do you take water to bed? ☐ Yes ☐ No
- ☐ Bones break easily
- ☐ Frequent cavities/teeth problems
- ☐ Kidney stones

Weight
- ☐ Underweight
- ☐ Overweight
- ☐ Normal
- ☐ Recent gain
- ☐ Recent loss
- ☐ If recent gain/loss, how much? _____
- ☐ Since what date? _____

Liver (Eyes)
- ☐ Itchy
- ☐ Bloodshot
- ☐ Hot
- ☐ Dry
- ☐ Watery
- ☐ Gritty/twitch/itch
- ☐ Blurry vision
- ☐ Decreased night vision
- ☐ Near-sighted
- ☐ Far-sighted
- ☐ Tear easily
- ☐ Color blind
- ☐ Glaucoma
- ☐ Macular degeneration

Liver, Pancreas, & Spleen
- ☐ Bruise easily
- ☐ Abdominal bloating
- ☐ Gurgling noise in stomach
- ☐ Prolapsed organs. Which? _____
- ☐ Worry/overthinking

Kidney & Bladder

Is your urine:
- ☐ Cloudy
- ☐ Dark yellow
- ☐ Clear
- ☐ Scanty
- ☐ Profuse
- ☐ Burning
- ☐ Frequent
- ☐ Urgent
- ☐ Difficult

- ☐ Bladder infections (UTIs)
- ☐ Lack of bladder control
- ☐ Wake during the night (2+ times) to urinate?

Thirst
- ☐ Normal
- ☐ Excessive
- ☐ Thirsty but do not drink
- ☐ No. of glasses per day: _____
- ☐ I prefer my drinks: ☐ cold ☐ warm/hot

Dampness trapped in the body
- ☐ Bodily sensation of heaviness
- ☐ Mental heaviness
- ☐ Mental sluggishness/fogginess
- ☐ Chest congestion
- ☐ Nausea
- ☐ Swollen joints

Bowels
- ☐ Gas
- ☐ Bloating
- ☐ Constipation
- ☐ Diarrhea
- ☐ Pain in stool passing
- ☐ Loose stool
- ☐ Incomplete stool
- ☐ Undigested food in stool
- ☐ Mucous in stool
- ☐ Blood in stool
- ☐ Chron's disease
- ☐ Ulcerative colitis

Stomach
- ☐ Pain
- ☐ Burning sensation after eating
- ☐ Acid reflux/heartburn
- ☐ Large appetite
- ☐ Lack of appetite
- ☐ Bad breath
- ☐ Hiccups/belching
- ☐ Vomiting
- ☐ Bleeding, swollen, or painful gums
- ☐ Canker sores (mouth)/tongue sores
- ☐ Ulcer (diagnosed)

Lung & Kidney
- ☐ Alternating chills/fever
- ☐ Dry nose/mouth/throat
- ☐ Sneezing
- ☐ Sinus congestion
- ☐ Allergies
- ☐ Nasal discharge color: _____
- ☐ Sore throat
- ☐ Cough
- ☐ Asthma
- ☐ Shortness of breath
- ☐ Difficulty breathing
- ☐ Stiff neck/shoulders
- ☐ Low energy/chronic fatigue
- ☐ General weakness
- ☐ Sad/melancholy
- ☐ Difficulty keeping eyes open

Men

- ☐ Swollen testes
- ☐ Testicular pain
- ☐ Impotence
- ☐ Premature ejaculation
- ☐ Feeling of numbness in genitals
- ☐ Other: _____

Women

- ☐ Nausea before/with mens.
- ☐ Anxiety
- ☐ Vomiting before/with mens.
- ☐ Food cravings
- ☐ Sleep disturbance
- ☐ Weepy/emotional
- ☐ Water retention
- ☐ Breast swelling
- ☐ Breast/nipple tenderness
- ☐ Vaginal dampness
- ☐ Vaginal pain/irritation
- ☐ Pain with intercourse
- ☐ Irritability
- ☐ Depression before/with mens.
- ☐ Dull pain (location): _____
- ☐ Other: _____

Menstruation

- ☐ Irregular
- ☐ Absent
- ☐ Diminished Flow
- ☐ Painful
- ☐ Lots of clots
- ☐ Heavy
- ☐ Frequent

Are you pregnant? ☐ Yes ☐ No

- ☐ Spotting (when?) _____
- ☐ Vaginal discharge (describe:) _____
- ☐ Use of birth control (type/for how long?) _____

Age of first menstruation: _____
Average number days in flow: _____
Average number days in cycle: _____
Number of pregnancies: _____
Age of menopause: _____

- ☐ PMS/PMDD

Libido

- ☐ High
- ☐ Average
- ☐ Low

Heart & Circulatory

- ☐ Anxiety
- ☐ Fatigue
- ☐ Sores on tip of tongue
- ☐ Swollen hands/feet
- ☐ Mental confusion
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Feel worse after exercising
- ☐ Restlessness
- ☐ Poor memory

Hair

- ☐ Dry
- ☐ Oily
- ☐ Dandruff
- ☐ Falling out
- ☐ Early grey
- ☐ Normal

Autoimmune

- ☐ Alopecia
- ☐ Addison's (AAD)
- ☐ Hepatitis
- ☐ Celiac
- ☐ Chron's
- ☐ Diabetes, Type I.
- ☐ Graves' disease
- ☐ Guillain-Barre Syndrome
- ☐ Hashimoto's thyroiditis
- ☐ Lupus
- ☐ Lyme disease
- ☐ Multiple Sclerosis (MS)
- ☐ Raynaud's
- ☐ Sjogren's Syndrome
- ☐ Ulcerative colitis
- ☐ Vitiligo
- ☐ Rheumatoid arthritis

Skin

- ☐ Dry
- ☐ Hives
- ☐ Itching
- ☐ Oily
- ☐ Acne
- ☐ Rashes
- ☐ Eczema/Psoriasis
- ☐ Cuts heal slowly
- ☐ Normal
- ☐ Other: _____

Nose/Mouth/Throat

- ☐ Stuffy nose
- ☐ Hay-fever
- ☐ Sneeze a lot
- ☐ Bleeding
- ☐ Loss of smell
- ☐ Sinusitis
- ☐ Runny nose
- ☐ Frequent colds
- ☐ Dry mouth
- ☐ Thyroid issues
- ☐ Lump in throat
- ☐ Gum problems
- ☐ Grind teeth

Pain

- ☐ Neck
- ☐ Back
- ☐ Shoulder
- ☐ Sciatica (legs)
- ☐ Hands/wrists
- ☐ Cramps Where? _____
- ☐ Hips
- ☐ Knees
- ☐ Feet/ankles
- ☐ Spine
- ☐ Arthritis
- ☐ Elbow
- ☐ Flank area
- ☐ Face
- ☐ Jaw
- ☐ Tension headache (where?) _____
- ☐ Migraine (where?) _____

Other: _____