**Acupuncture Additional Intake Information**

#### All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

**Name**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

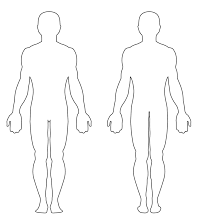
**Date of Birth**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Gender**: M/F /Other

**Pain**

Do you have any pain? Yes No

Please mark areas of pain

Front : Back :



If Yes, Where and for how long? ­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Rate on a scale of 1 -10: 1 2 3 4 5 6 7 8 9 10

**Name**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **DOB**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Lifestyle Questions:

Which of the following do you do on a regular basis? (Please check all that apply)

Bicycling Jogging Pilates Swimming Weightlifting Yoga Meditation

Walking Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How do you relax? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Nutrition**

How many meals do you generally eat each day? 1 2 3 4 5 6

List the foods you exclude from you diet:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What temperature do you prefer your drinks? Hot Cold Room Temperature

Are you satisfied with your diet as it is now? Yes No

If no, why not? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Sleep**

Do you sleep straight through the night? Y/N If not, what time do you wake up?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How long do you stay awake? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How many hours per night do you generally sleep? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you wake feeling refreshed? Y/N Do you have trouble falling asleep? Y/N

**Name**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **DOB**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Please check all that apply:***

**Endocrine**

 Cold hands or feet  Easily stressed  Increased hunger  Irritable/restless

 Sensitive to cold  Unexplained weight loss/gain

**Respiratory**

 Asthma/Wheezing  Daily Cough  Frequent Colds  Tuberculosis

 Hay Fever  Loss of smell  Persistent hoarseness

Other Respiratory Problems: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please check any that you experience now and any that you have experienced in the past:

 Bronchitis  Pneumonia  Tonsillitis

**Cardiovascular**

 Heart Beating Fast  Fibrillation  High Blood Pressure  Palpitations/Fluttering Stroke

 Chest Pain  Heart Murmur; type \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Neurologic**

 Heart Beating Slow  Heart Disease  Leg pain when walking  Rheumatic Fever

 Swelling of Ankles  Skipping Beats  Varicose Veins  Paralysis

 Numbness/Tingling  Vertigo/Dizziness  Loss of balance

**Gastrointestinal**

 Tend to Constipation  Tend to Loose Stools  Chronic Diarrhea  Hemorrhoids

 Bloating/Gas  Abdominal Cramping  Blood in Stool

**Name**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **DOB**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Genito-Urinary Tract**

 Blood in Urine  Frequent Urination  Heavy Flow  Kidney Stones

 Difficulty holding Urine  Night Urination  Painful Urination

**Female Reproductive**

 Breast Lumps/Tenderness  Low libido  Painful sex  Vaginal Discharge

 Difficulty Conceiving  Menopausal Symptoms  Pelvic pain

Length of Cycle: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Color of blood: red dark red purple clots light red brown

Have you had complications with pregnancy? Yes No If yes, please explain; \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please check all menstrual and premenstrual-related symptoms that you experience now and any that you have experienced in the past:

 Abdominal bloating  Breast tenderness  Craving for sweets  Heavy Flow

 Dizziness or fainting  Headache  Increased appetite  Irritability

 Painful Periods  Weight gain  Anxiety  Mood Changes

 Bleeding between Cycles  Confusion  Depression  Irregular Cycles

**Male Reproductive**

 Prostate Problems  Low Back Pain  Neck/Shoulder Pain Swelling

 Anxiety or Fear  Despair/discontent  Memory difficulty  Nervousness

 Suicidal thoughts  Infertility  Testicular Swelling  Sexual Difficulty

Date of last prostate exam: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Was it normal? Yes No

**Other**

Any obstacles to perfect health, which have not been covered?