



70 Woodfin Place, Suite 417, Asheville, NC 28801 • 828.348.4898

This is a CONFIDENTIAL questionnaire to help us work together to determine the best treatment plan for you. Please fill it out as completely as possible, even if you do not feel that certain questions or conditions pertain to your present condition. Thank You.

Name _____ Date _____

Street Address _____

City/State/Zip _____

Telephone (H) _____ (W) _____ (C) _____

E-mail _____ Social Security # _____

Date of Birth _____ Age _____

If under 18, person responsible for your account

Emergency Contact: _____ Phone: _____ Relation _____

Whom should we thank for referring you to our office? _____

Who is your Healthcare Provider? _____

Address _____ Phone _____

Date of Last Physical Exam _____

Health History

Place a (✓) if you experience any of the following:

(marking “yes” does not make you ineligible for treatment, however, it may restrict some of our treatment modalities):

- Hepatitis HIV High Blood Pressure Seizures Pacemaker
 Blood-Thinning Meds Pregnancy MRSA

Please indicate the use and frequency of the following:

Water _____ x/day Coffee/Caffeine Tea _____ x/day Soda _____ x/day

Alcohol _____ x/day Recreational Drugs _____ x/day Tobacco _____ x/day

Please list any Prescription, Over-The-Counter medications, or Supplements you are currently taking:

Prescription, OTC, Supplements	Reason for Taking	Dosage per Day

Please list any known allergies (Medications, Environmental, Skin, Food, etc.)

Have you had acupuncture therapy before? Yes No With Whom? _____

Please list your Primary Health Concerns?

How long have you had these conditions?

What other forms of treatment have you sought?

What helps your condition?

What aggravates your condition?

Secondary Health Concerns:

Please list any surgeries or major health incidents (accidents, etc.) in your life:

Surgeries, Accidents, Trauma, Major Illnesses	Relevant Info.	Date

Please (✓) the following:

You

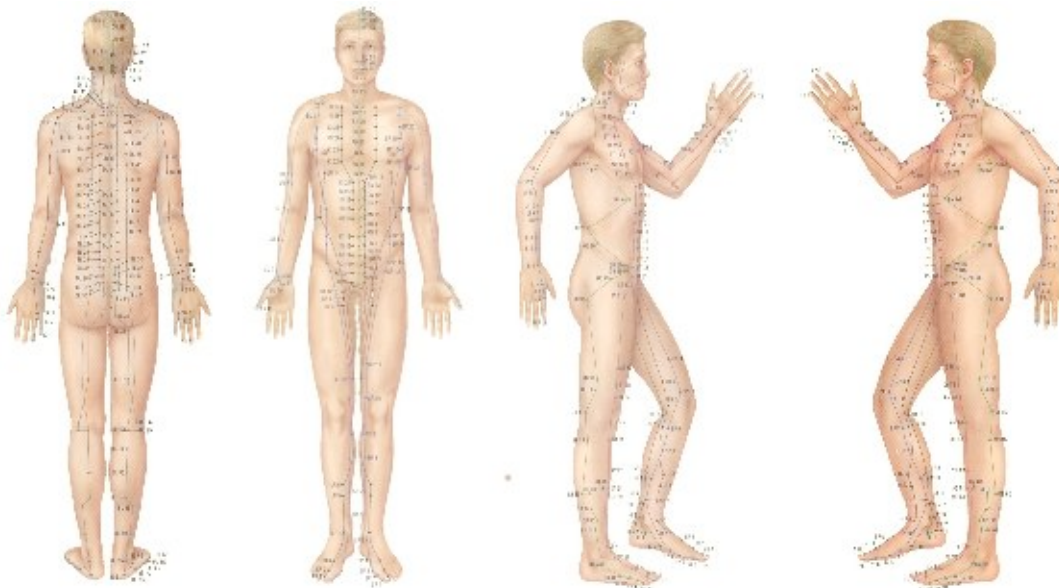
Family (Whom?)

- | | | |
|------------------------------|--------------------------|--------------------------|
| Diabetes: | <input type="checkbox"/> | <input type="checkbox"/> |
| Heart Disease: | <input type="checkbox"/> | <input type="checkbox"/> |
| High Blood Pressure: | <input type="checkbox"/> | <input type="checkbox"/> |
| High Cholesterol: | <input type="checkbox"/> | <input type="checkbox"/> |
| Cancer: | <input type="checkbox"/> | <input type="checkbox"/> |
| Auto Immune Disorders: _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| Mental Illness: _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| Genetic Disorders: _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| Arthritis: | <input type="checkbox"/> | <input type="checkbox"/> |

Pain

Please indicate in the figures below your area(s) and quality of pain:

- | | | | |
|----------------------|----------------|------------------|----------------|
| (AAA) Dull/Achy | (BBB) Burning | (EEE) Electrical | (NNN) Numbness |
| (SSS) Sharp/Stabbing | (TTT) Tingling | | |



Grade Intensity/Severity

(No complaint/pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst pain/complaint imaginable)

How frequent is complaint present, how long does it last?

♀ **For Women**

Are you currently pregnant? _____ If so, how many weeks? _____

Age: First period _____ Day 1 of last period _____ Menopause _____

Date: Last Pap _____ Results _____ Breast Exam _____ Results _____

Please indicate the following #:

Pregnancies _____ Live Births _____ Miscarriages _____ Abortions _____

Number of days between periods _____ Number of days of flow _____

Please (✓) the following that apply:

Color of flow: pale/light red red dark red/purple brown

Amount of flow : spotting light moderate heavy

Clots (if applicable): small (raisin) large (grape) dark red dark purple

Number of pads/tampons per day: 1st day ____ 2nd day ____ 3rd day ____ 4th+ day ____

Pain and cramping: No Yes mild moderate severe

before during after

Please (✓) other symptoms you may experience before, during, or after menstruation:

Vaginal Discharge (unusual) PMS Headache Nausea Vomiting

Constipation Diarrhea Swollen Breasts Mood Swings

Increased Appetite Decreased Appetite Pain during Intercourse

Have you ever been diagnosed with:

Fibroids Fibrocystic breasts Endometriosis Ovarian Cysts

Pelvic Inflammatory Disease Polycystic ovary Syndrome STD _____

For Men

Date of last Prostate exam _____ Results _____ PSA test results _____

Date of last Colonoscopy _____ Results _____

Please (✓) the following that apply:

- Erectile Dysfunction
- Testicular Pain or Swelling
- Pain during Intercourse
- Unusual Sores, bumps or lesions on testes, penis, or anus
- Premature Ejaculation
- Waking at Night to Urinate
- Itching for flaking of penile skin
- Abnormal Discharge
- Painful Urination

Goals

What are your top three (3) goals you would like to work on?

- 1.
- 2.
- 3.

Are you interested in additional health services besides acupuncture? Yes No

Please (✓) which services you would be interested in:

- Chinese Herbal Therapy
- Therapeutic massage
- Nutritional Counseling
- Lifestyle Modification
- Tai chi
- Qi gong health exercises
- Relaxation/Meditation techniques
- Other _____