



128 S. Eagle Road, Eagle, ID 83616 (208)-938-1277 www.AmericanAcu.com

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

Personal Information

Name _____ Age _____ Birth Date _____

Address _____

City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Mobile _____

E-mail _____ If under 18, person responsible for your account _____

Emergency Contact: Name _____ Contact Phone: _____

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

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

Please indicate if any of the following pertain to you: (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

Please indicate the use and frequency of the following:

Coffee _____ Soda pop _____ Water _____

Alcohol _____ Recreational drugs _____ Tobacco _____

Please list any prescription or over-the-counter medications and supplements you are presently taking:

Medications and Supplements	Reason
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Health History

What are the health problems for which you are seeking treatment? _____

How long have you had this condition? _____

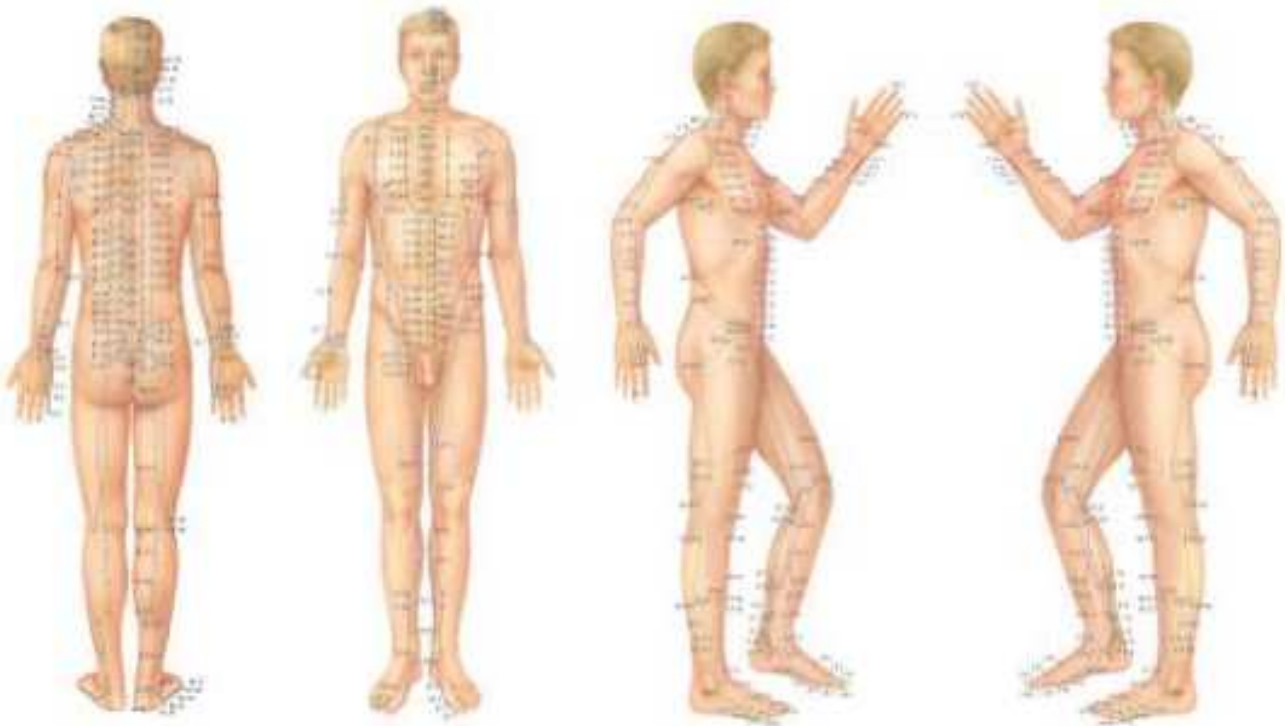
What other forms of treatment have you sought? _____

What helps your condition? _____

What aggravates your condition? _____

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

PAIN PATIENTS, please indicate on the figures below the areas of the body you experience your pain:



How would you characterize your pain: dull/achy sharp/stabbing burning tingling numbness electrical

What would you like to achieve with acupuncture treatment? _____

Symptom Survey

Please “check” the symptoms or conditions you experience **frequently**:

Sp/St	Ht/P	Lu/LI	Ki/UB	Liv/GB
<input type="checkbox"/> excessive appetite	<input type="checkbox"/> insomnia	<input type="checkbox"/> cough	<input type="checkbox"/> low back pain	<input type="checkbox"/> eye problems
<input type="checkbox"/> loose stool/diarrhea	<input type="checkbox"/> palpitations	<input type="checkbox"/> shortness of breath	<input type="checkbox"/> knee problems	<input type="checkbox"/> jaundice
<input type="checkbox"/> digestive problems, indigestion	<input type="checkbox"/> cold hands and feet	<input type="checkbox"/> decreased sense of smell	<input type="checkbox"/> hearing impairment	<input type="checkbox"/> difficulty digesting oily foods
<input type="checkbox"/> vomiting	<input type="checkbox"/> nightmares	<input type="checkbox"/> nasal problems	<input type="checkbox"/> ear ringing	<input type="checkbox"/> gall stones
<input type="checkbox"/> belching, burping	<input type="checkbox"/> mentally restless	<input type="checkbox"/> skin problems	<input type="checkbox"/> kidney stones	<input type="checkbox"/> light-colored stool
<input type="checkbox"/> heartburn/reflux	<input type="checkbox"/> laughing for no reason	<input type="checkbox"/> claustrophobia	<input type="checkbox"/> decreased sex drive	<input type="checkbox"/> soft or brittle nails
<input type="checkbox"/> stomach bloating	<input type="checkbox"/> chest pains	<input type="checkbox"/> colitis/diverticulitis	<input type="checkbox"/> hair loss	<input type="checkbox"/> easily angered
<input type="checkbox"/> obsession in work, relationships, etc.	<input type="checkbox"/> poor memory	<input type="checkbox"/> constipation	<input type="checkbox"/> urinary problems	<input type="checkbox"/> difficulty in making decisions
<input type="checkbox"/> lack of appetite	<input type="checkbox"/> sadness	<input type="checkbox"/> blood in stool	<input type="checkbox"/> easily bruised	<input type="checkbox"/> high cholesterol
		<input type="checkbox"/> hemorrhoids	<input type="checkbox"/> dental problems	<input type="checkbox"/> bitter taste
		<input type="checkbox"/> recent use of antibiotics		
<input type="checkbox"/> fatigue	<input type="checkbox"/> edema	<input type="checkbox"/> asthma	<input type="checkbox"/> allergies	<input type="checkbox"/> dizziness
<input type="checkbox"/> I usually feel warm	<input type="checkbox"/> I usually feel chilled			<input type="checkbox"/> get sick easily
				<input type="checkbox"/> headaches

♀ For Women

Age of first period _____ Date of last period _____ Number of children (live births) _____

Number of days between periods (your cycle) _____ Number of days of flow _____

Color of flow:

- pale/light red
- red
- bright red
- dark red
- dark red/brown clots

Amount of flow:

- spotting
- light
- even throughout
- heavy

of pads you use per day:

- 1st day _____
- 2ND day _____
- 3RD day _____
- 4th day _____
- +days _____

Pain and cramping:

- No
- Yes
 - before flow
 - during flow
 - after flow
- mild
- moderate
- severe

Other symptoms related to menses:

- Discharge
- PMS
- Headache
- Nausea
- Constipation
- Diarrhea
- Swollen Breasts
- Mood Swings
- Increased Appetite
- Decreased Appetite
- Insomnia

Have you ever been diagnosed with: fibroids fibrocystic breasts endometriosis ovarian cysts PID
 polycystic ovary syndrome STD _____

Please indicate if the following pertain to you:

Kidney Yin-

- Do you have lower back weakness, soreness or pain?
- Do you have ringing in your ears?
- Is your hair prematurely gray?
- Do you have vaginal dryness?
- Is your mid-cycle cervical mucus scanty or missing?
- Do you have dark circles under your eyes?
- Do you have night sweats?
- Are you prone to hot flashes?
- Would you describe yourself as “afraid” frequently?
- Do you have dizziness?
- Do you have knee problems?

Kid Yang-

- Do you have low back pain pre-menstrually?
- Is your back sore or weak?
- Are your feet cold, especially at night?
- Are you typically colder than those around you?
- Is your libido low?
- Are you often fearful?
- Do you wake up at night or early in the morning because you have to urinate?
- Do you urinate frequently, and is the urine diluted and/or profuse?
- Do you have early morning loose, urgent stools?
- Do you have profuse vaginal discharge?
- Do you feel cold cramps during your period that respond to a heating pad?

Spleen-

- Are you often fatigued?
- Do you have poor appetite?

- Is your energy low after a meal?
- Do you feel bloated after eating?
- Do you crave sweets?
- Do you have loose stools, abdominal pain, or digestive problems?
- Are your hands and feet cold?
- Are you prone to feeling sluggish?
- Are you prone to heaviness or grogginess in the head?
- Do you have varicose veins?
- Are you prone to worry?
- Have you been diagnosed with low blood pressure?
- Do you sweat a lot without exerting yourself?
- Do you feel dizzy or light-headed, or have visual changes when you stand up fast?
- Is your menstruation thin, watery, profuse, or pinkish in color?
- Are you more tired around ovulation or menstruation?
- Do you ever spot a few days or more before your period comes?
- Have you ever been diagnosed with uterine prolapse?
- Are your menstrual cramps accompanied by a bearing down sensation in your uterus?
- Are you often sick, or do you have allergies?
- Have you ever been diagnosed with hypothyroid or anemia?
- Do you have hemorrhoids or polyps?

Blood-

- Are your menses scant or late?
- Do you have dry, flaky skin?
- Are you prone to getting chapped lips?
- Are your fingernails or toenails brittle?
- Are you losing hair on your head?
- Is your hair brittle or dry?
- Do you have diminished nighttime vision?
- Do you get dizzy or light-headed around your period?
- Are your lips, the inner side of your lower eyelids, or tongue pale in color?

Blood stasis

- Is your menstrual flow ever brown or black in color?
- Do you feel mid-cycle pain around your ovaries?
- Do you have painful, unmovable breast lumps?
- Do you experience periodic numbness of your hands and feet, especially at night?
- Do you have varicose or spider veins?
- Do you have red cherry spots (hemangiomas) on your skin?
- Do you have chronic hemorrhoids?
- Does your menstrual blood contain clots?
- Have you been diagnosed with endometriosis or uterine fibroids?
- Do you have piercing or stabbing menstrual cramps?
- Do you have dark spots in your eyes?
- Have you been diagnosed with any vascular abnormality or blood clotting disorder?

Liver Stagnation

- Are you prone to emotional depression?
- Are you prone to anger and/or rage?
- Do you become irritable premenstrually?
- Do you feel bloated or irritable around ovulation?
- Does it feel as if your ovulation lasts longer than it should?
- Are your breasts sensitive/sore at ovulation?
- Do you experience nipple pain or discharge from your nipples?
- Do you have a lot of pre-menstrual breast distension or pain?
- Do you become bloated pre-menstrually?
- Are your pupils usually dilated and large?
- Do you have difficulty falling asleep at night?
- Do you experience heartburn or wake up with a bitter taste in your mouth
- Are your menses painful?
- Do you feel your menstrual cramps in the external genital area?
- Is your menstrual blood thick and dark, or purplish in color?

Heart-

- Do you wake up early in the morning and have trouble getting back to sleep?

- Do you have heart palpitations, especially when anxious?
- Do you have nightmares?
- Do you seem low in spirit or lacking vitality?
- Are you prone to agitation or extreme restlessness?
- Do you fidget?
- Do you sweat excessively, especially on your chest?

Excess Heat

- Are your mouth and throat usually dry?
- Are you often thirsty for cold drinks?
- Do you often feel warmer than those around you?
- Do you wake up sweating or have hot flashes?
- Do you breakout with red acne, especially pre-menstrually?
- Do you have a short menstrual cycle?
- Do you have vaginal irritation?

Dampness

- Do you feel tired and sluggish after a meal?
- Do you have fibrocystic breasts?
- Do you have cystic or pustular acne?
- Do you have urgent, bright, or foul-smelling stools?
- Does your menstrual blood contain stringy tissue or mucus?
- Are you prone to yeast infections and vaginal itching?
- Are you overweight?
- Do you have a wet, slimy tongue?
- Does your body feel like a barometer? Can you sense when it will rain?

Fertility Information

of IVF procedures _____ # of IUI procedures _____

Has a physician diagnosed a difficulty with fertility due to: Female Factor Male Factor Unexplained

Other _____

Conclusion

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

Please check which services you would be interested in: Chinese herbal medicine Therapeutic massage

Tai chi Qi gong health exercises Relaxation techniques Nutritional consultation

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