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New Patient Questionnaire

Patient Name			
Email			
Mailing address			
Phone		D.O.B.	
Height / weight		Referred by	
Emergency Contact (Name and Phone #)			

What is your main complaint?

When did this problem first begin? How often does this bother you?

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Severity of the problem on a scale of 1-10 (0=best; 10=worst)

Have you received acupuncture or Oriental medicine before?

- [ ] Yes
- [ ] No

If there is pain involved, what is the quality of the pain? (Select all that apply)

- [ ] Dull
- [ ] Achy
- [ ] Burning
- [ ] Sharp
- [ ] Stabbing
- [ ] Cold
- [ ] Numb
- [ ] Tingling

What makes the problem feel better? (Select all that apply)

- [ ] Heat
- [ ] Cold
- [ ] Damp weather
- [ ] Wind
- [ ] Rest
- [ ] Work
- [ ] Other

To what extent does this problem interfere with your daily activities (work, sleep, sex, etc)?

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Have you been given a diagnosis for this problem?

- [ ] Yes
- [ ] No

What kinds of treatment have you tried?

Significant trauma (physical or emotional)?

Surgeries? Please include date(s) of procedure(s).

Allergies (chemical, environmental, food, drugs, etc)?

Medications (names and dosages?

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Vitamins/supplements/herbs

Exercise: Length of workout, type of activity, days per week

Diet: Meals per day, snacks, caffeinated drinks, alcohol per week

PERSONAL HISTORY

Please select any conditions or symptoms you have now or have had in the past.

- ☐ Arthritis
- ☐ High/Low Blood Pressure
- ☐ Thyroid Imbalance
- ☐ Cancer
- ☐ Ulcer
- ☐ Chronic Pain
- ☐ Gastritis/Pancreatitis
- ☐ Bleeding Tendency
- ☐ Meningitis
- ☐ Liver/Gall Bladder Disease
- ☐ Hypo/Hyperglycemia
- ☐ Diabetes
- ☐ Respitory Allergies
- ☐ Impotence
- ☐ Emphysema
- ☐ Chronic Fatigue
- ☐ Alcoholism
- ☐ Hepatitis
- ☐ Asthma
- ☐ Migraines
- ☐ Migraines
- ☐ Heart Disease
- ☐ High Cholesterol
- ☐ Diverticulititis/IBS
- ☐ Raynaud's Disease
- ☐ Infertility
- ☐ Nervous Disorders
- ☐ Kidney Disease
- ☐ Food Allergies / Intolerance
- ☐ Seizures
- ☐ Anemia
- ☐ Lyme Disease
- ☐ HIV / AIDS
- ☐ Syphilis
- ☐ Other
- ☐ None of the above

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FAMILY MEDICAL HISTORY

Please select any conditions or symptoms you have now or have had in the past.

- [ ] Diabetes
- [ ] High Blood Pressure
- [ ] Seizures
- [ ] Allergies
- [ ] Heart Disease
- [ ] Cancer
- [ ] Stroke
- [ ] Asthma
- [ ] Other

GENERAL

Please select any conditions or symptoms you have now or have experienced in the past year.

- [ ] Poor Appetite
- [ ] Chills
- [ ] Cravings
- [ ] Bleed/Bruise Easily
- [ ] Muscle Weakness/Fatigue
- [ ] Poor Sleeping
- [ ] Night Sweats
- [ ] Localized Weakness
- [ ] Weight Loss/Gain
- [ ] Sudden Energy Drop
- [ ] Fatigue
- [ ] Sweats Easily
- [ ] Poor Balance
- [ ] Peculiar Tastes/Smells
- [ ] Strong Thrist
- [ ] Fevers
- [ ] Tremors
- [ ] Change in Appetite
- [ ] Dental / Gum Problems

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SKIN AND HAIR

- [ ] Rashes
- [ ] Eczema / Psoriasis
- [ ] Skin Discoloration
- [ ] Dermatitis
- [ ] Ulcerations
- [ ] Dandruff
- [ ] Acne
- [ ] Warts
- [ ] Hives / Allergic
- [ ] Loss of Hair
- [ ] Change in Skin / Hair Texture
- [ ] Itching
- [ ] Recent Moles
- [ ] Face Flushing
- [ ] Weak or Ridged
- [ ] Fungal Infection

HEAD, EYES, EARS, NOSE AND THROAT

- [ ] Dizziness
- [ ] Eye Strain
- [ ] Color Blindness
- [ ] Ringing in Ears
- [ ] Nose Bleeds
- [ ] Sores on Lips / Tongue
- [ ] Difficulty Swallowing
- [ ] Eye Pain
- [ ] Cataracts
- [ ] Poor Hearing
- [ ] Recurrent Sore Throats
- [ ] Recurrent Colds
- [ ] Migraines
- [ ] Poor Vision
- [ ] Blurred Vision
- [ ] Spots in Front of Eyes
- [ ] Grinding Teeth
- [ ] Jaw Clicks / Locks
- [ ] Glasses
- [ ] Night Blindness
- [ ] Earaches
- [ ] Sinus Problems
- [ ] Facial Pain
- [ ] Headaches
- [ ] Dental Problems

CARDIOVASCULAR

- [ ] Chest Pain or Pressure
- [ ] Cold Hands / Feet
- [ ] Shortness of Breath
- [ ] Low Blood Pressure
- [ ] Irregular Heart Beat
- [ ] Swelling of Hands / Feet
- [ ] Varicose / Spiner Veins
- [ ] High Blood Pressure
- [ ] Palpitations at Rest
- [ ] Blood Clots
- [ ] Pressure in Chest
- [ ] Spontaneous Sweating
- [ ] Fainting
- [ ] Phlebitis
- [ ] Dizziness
- [ ] Raynaud's Disease

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RESPIRATORY

- [ ] Coughing / Wheezing
- [ ] Pneumonia
- [ ] Difficulty Breathing When Lying Down
- [ ] Coughing Blood
- [ ] Pain with Deep Inhalation
- [ ] Asthma
- [ ] Tight Sensation in Chest
- [ ] Production of Phlegm
- [ ] Bronchitis
- [ ] Difficulty Inhaling / Exhaling

GASTROINTENSTINAL

- [ ] Nausea
- [ ] Gas
- [ ] Indigestion
- [ ] Bloating / Edema
- [ ] Changes in Appetite
- [ ] Excessive Appetite
- [ ] Vomiting
- [ ] Belching
- [ ] Bad Breath
- [ ] Chronic Laxative Use
- [ ] Acid Reflux / GERD
- [ ] Significant Thrist
- [ ] Diarrhea
- [ ] Black Stools
- [ ] Rectal Pain
- [ ] Loose Stools (>2 per day)
- [ ] Hernia
- [ ] IBS / Crohn's Disease
- [ ] Constipation
- [ ] Blood in Stool
- [ ] Hemorrhoids
- [ ] Abdominal Pain / Cramps
- [ ] Poor Appetite

GENITOURINRY

- [ ] Pain on Urination
- [ ] Frequent Urination
- [ ] Urgent Urination
- [ ] Burning Urination
- [ ] Blood in Urine
- [ ] Night Urination
- [ ] Urinary Tract Infection
- [ ] Dribbling After Urination
- [ ] Premature Ejaculation
- [ ] Nocturnal Emission
- [ ] Kidney Stones
- [ ] Scanty Flow
- [ ] Copious Flow
- [ ] Impotence
- [ ] Sores on Genitals
- [ ] Pain in Testicles
- [ ] Decreased Libido
- [ ] Prosatitis
- [ ] Herpes
- [ ] Excessive Libido
- [ ] Low Libido

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GYNOCOLOGICAL / RPRODUCTIVE (Women Only)

- ☐ Difficult / Painful Intercourse
- ☐ Vaginal Dryness / Itching
- ☐ Vaginal Sores
- ☐ Vaginal Discharge
- ☐ Polycystic Ovarian Syndrome
- ☐ Infertility
- ☐ Pregnancies
- ☐ Miscarriages
- ☐ Ovarian Cysts
- ☐ Endometriosis
- ☐ Uterine Fibroids
- ☐ Fibrocystic Breast Tissue
- ☐ STD
- ☐ Births

Please list any birth control medications and duration of use:

MEN'S HEALTH

- ☐ Swollen Testes
- ☐ Testicular Pain
- ☐ Enlarged Prostate
- ☐ Premature Ejaculation
- ☐ Impotence
- ☐ Cancer (Prostate or Testicular)
- ☐ Feeling of Coldness or Numbness in External Genitalia
- ☐ Difficult Urination (Weak Stream or Dribbling)
- ☐ STD

MUSCULOSKELETAL

- ☐ Neck Pain
- ☐ Knee Pain
- ☐ Hip Pain
- ☐ Back Pain
- ☐ Shoulder Pain
- ☐ Muscle Pain
- ☐ Sprains / Strains
- ☐ Soreness / Weakness in Lower Body
- ☐ Hand / Wrist Pain
- ☐ Sciatica
- ☐ Muscle Weakness
- ☐ Bursitis
- ☐ Carpal Tunnel
- ☐ Foot / Ankle Pain
- ☐ Tendonitis
- ☐ Rotator Cuff

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NEUROPSYCHOLOGICAL

- [ ] Seizures
- [ ] Lack of Coordination
- [ ] Anxiety / Panic Attacks
- [ ] Nervousness
- [ ] Loss of Balance
- [ ] Poor Memory
- [ ] Bad Temper / Irritable
- [ ] Manic Depression
- [ ] ADD / ADHD
- [ ] Vertigo / Dizziness
- [ ] Areas of Numbness
- [ ] Depression
- [ ] Seasonal Affective Disorder
- [ ] Easily Susceptible to Stress
- [ ] Concussion

Have you ever been treated for emotional problems?

- [ ] Yes
- [ ] No

Please inform me of any other problems you would like to discuss:

- [ ] To the best of my knowledge, the questions on this form have been accurately answered.

I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform my provider of any changes in my medical status. I also authorize the healthcare staff to perform the necessary healthcare services I may need.

Initials

Today's Date