Acupuncture Changes Lives

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Full Name

Age

Date of Birth
MM / DD / YY

How did you hear about us?

Gender F M X

Transgender Y N

Intersex Y N

Have you ever had acupuncture before? ☐ Yes ☐ No

What is your chief complaint?

When did it start?

What led to this problem?

Does this interfere with any of the following:
☐ Standing ☐ Sitting ☐ Walking ☐ Sleeping ☐ Work ☐ Exercise
☐ Intimacy ☐ Other ____________________

What kinds of treatment have you tried?
☐ Rest ☐ Medications
☐ Chiropractic ☐ Other
☐ Physical Therapy ____________________
☐ Surgery ____________________

What makes it worse?
☐ Weather ☐ Position ☐ Standing ☐ Sitting
☐ Stress ☐ Applying Heat ☐ Applying Cold
☐ Other ____________________

What makes it better?
☐ Applying Heat ☐ Applying Cold ☐ Rest ☐ Exercise
☐ Stretching ☐ Other ____________________

Is there anything else you feel I should know?

What are you hoping to get out of the session?

"The doctor of the future will give no medicine, but will instruct his patient in the care of the human frame, in diet and in the cause and prevention of disease."

\- Thomas Edison

Check one box for each:	Never	Rarely	Sometimes	Often	Always
Breakfast					
Lunch					
Dinner					
Meals or snacks shortly before bed					
Skipped meals					
Snacks					
Dark Greens					
Other Veggies					
Vegetable Protein					
Whole Grains					
Salads/Raw Foods					

	Never	Rarely	Sometimes	Often	Always
Fish					
Meat					
Dairy					
Soy Products					
Fast Food					
Fried Food					
Sugary Foods					
Processed Foods					
Soda					
Coffee					
Water					

Do you think your diet contributes to your current symptoms?

If so, what obstacles hold you back?

☐ Knowledge ☐ Habit ☐ Emotions

☐ Other ______________________

"IT IS THE GREATEST OF ALL MISTAKES TO DO NOTHING BECAUSE YOU CAN ONLY DO A LITTLE. DO WHAT YOU CAN."

- Sydney Smith

What kinds of exercise do you do, and how often?	Never	Rarely	Sometimes	Frequently
Walking				
Running				
Swimming				
Biking				
Weight Lifting				
Stretching				

	Never	Rarely	Sometimes	Frequently
Aerobics				
Yoga				
Qi Gong / Tai Chi				
Martial Arts				
Other:				

Do you have any physical limitations on your exercise?

What do you do for a living?

Describe your work activities:

☐ Physical ☐ Sitting all day ☐ Customer service oriented ☐ Phones all day
☐ Travel ☐ On your feet all day ☐ Frequent/extended bending or leaning over
☐ Other ______________________

What level of stress do you experience at work? Circle one.

Physical: (Negligible) 1 2 3 4 5 6 7 8 9 10 (Intolerable)

Mental: (Negligible) 1 2 3 4 5 6 7 8 9 10 (Intolerable)

Is your work rewarding for you? ☐ Y ☐ N
Is your work high stakes? ☐ Y ☐ N
Is your work deadline driven? ☐ Y ☐ N
Do you have predictable hours? ☐ Y ☐ N
Are you self-employed? ☐ Y ☐ N
Do you change jobs often? ☐ Y ☐ N

Work environment? ☐ Enjoyable ☐ Neutral ☐ Negative

How is your overall energy level? Circle one. (Low) 1 2 3 4 5 6 7 8 9 10 (High)

Do you have the energy for day to day activities? ☐ Yes ☐ No ☐ ______________

Do you experience any of the following:

☐ Energy drop mid-morning ☐ Energy drop after lunch ☐ Energy drop just after work
☐ Low motivation ☐ Low libido
☐ Other low energy times ______________________

Check one box for each:

	Never	Rarely	Sometimes	Often	Every Night
Do you sleep well?					
Do you sleep enough?					
Are you tired when you wake up?					
Do you stay tired all day?					
Do you take medication to help with sleep?					
Do you drink coffee to wake up?					
Do you fall asleep easily?					
Do you wake at night?					
Do you sleepwalk?					
Do you have nightmares?					
Do you have a predictable sleep schedule?					

How many hours do you sleep per night? ______________

How many hours makes you feel your best? ______________

Health History

Check one box for each:

	SELF			FAMILY				
	Recent	Chronic	Recovered	Parent	Sibling	Grandparent Aunt/Uncle	Spouse	Child
Asthma								
Breathing Problems								
Cancer								
Diabetes								
Thyroid Disorder								
Seizures								
Heart Disease								
Hypertension								
Stroke								
Miscarriage								
Digestive Disorders								
Hepatitis								
AIDS / HIV Positive								
STD								
Addiction								
Other								

"Knowing ignorance is strength,

Ignoring knowledge is sickness.

If one is sick of sickness, then one is not sick.

The wise one is not sick, because he is sick of sickness."

-Tao Te Ching

If you have seasonal allergies, when do they occur?

☐ Winter ☐ Spring ☐ Summer ☐ Fall ☐ Other ______

Environmental allergies?

☐ Dust ☐ Pets ☐ Mold ☐ Other ______

Dietary allergies?

☐ Dairy ☐ Wheat ☐ Corn ☐ Nuts ☐ Other ______

Do you experience the following symptoms?

☐ Nasal congestion ☐ Runny nose ☐ Drainage ☐ Chronic sore throat ☐ Headaches
☐ Itchy eyes/ears/nose ☐ Watery eyes ☐ Red eyes ☐ Body aches ☐ Low energy
☐ Other specific time ______

Do you experience any of the following?

☐ Seasonal cold/flu ☐ Seasonal bronchitis ☐ Sinus infections after allergies ☐ Flu shots
☐ Other ______

Do you have any additional important information about your immune system?

How many hours do you spend in front of a computer monitor? _____ hours / week

How many hours do you spend otherwise reading or focusing your eyes? _____ hours / week

Do you do eye exercises? How long have you been doing them?

Do you experience any of the following?

☐ Blurry vision ☐ Red eyes ☐ Allergy symptoms ☐ Tired eyes ☐ Eye aches

☐ Other ______________________________

Do you commonly experience any of the following digestive symptoms?

☐ **Acid reflux:** How often? ______________________________
Triggered by: ☐ Stress ☐ Spicy food ☐ Oily food ☐ Eating too late
☐ Other ______________________________

☐ **Indigestion:** ☐ Pain ☐ Gas, mild odor ☐ Gas, strong odor ☐ Bloating
☐ Other ______________________________

☐ **Constipation:** How long between bowel movements? ______________________________
Describe: ☐ Dry ☐ Painful ☐ Difficult ☐ Bleeding
☐ Other ______________________________

☐ **Diarrhea:** ☐ Watery ☐ Undigested food ☐ Incontinence ☐ Other ______________

☐ **Hemorrhoids:** ☐ Internal ☐ External ☐ Bleeding ☐ Postpartum
☐ Other ______________________________

☐ **Bowel movements that look like coffee grounds**

A Short History of Medicine

2000 B.C. - "Here, eat this root."

1000 B.C. - "That root is heathen, say this prayer."

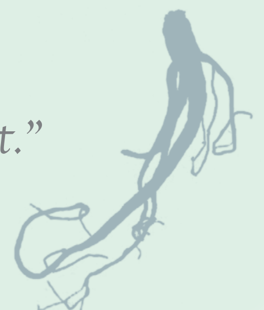
1850 A.D. - "That prayer is superstition, drink this potion."

1940 A.D. - "That potion is snake oil, swallow this pill."

1985 A.D. - "That pill is ineffective, take this antibiotic."

2000 A.D. - "That antibiotic is artificial. Here, eat this root."

- Author Unknown



Do you commonly experience any of the following urinary symptoms?

☐ **General:** ☐ Weak flow ☐ Sense of urgency ☐ Pain ☐ Burning
☐ Incompleteness (having to go again shortly after) ☐ Waking at night
☐ Dribbling: ○ Postpartum ○ Post operative ○ Other ____________
☐ Other ____________

☐ **Prostate Issues:** ☐ Less flow ☐ Pain ☐ Enlarged prostate
☐ Prescription(s) ____________
☐ Procedures ____________

Do you have any concerns about your interest in sex? ☐ Y ☐ N
Healthy functions? ☐ Y ☐ N

Are you taking any medications that effect libido?

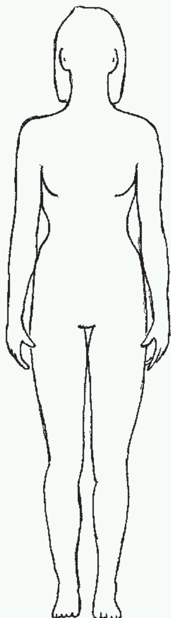
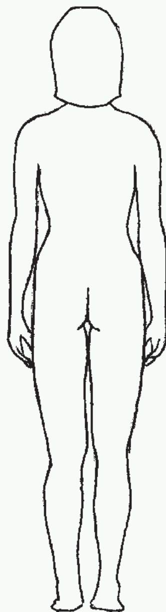
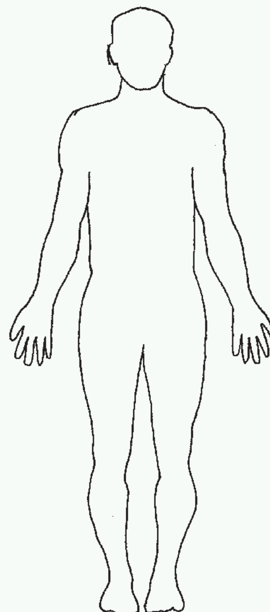
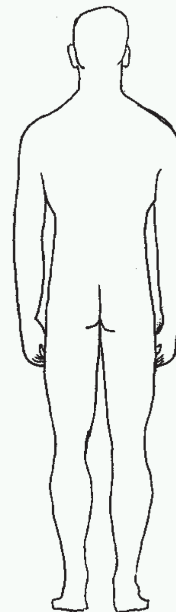
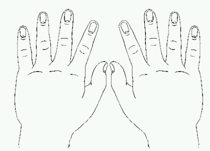
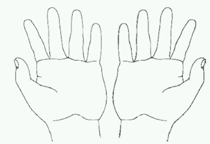
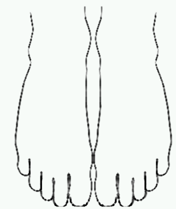
"Luminous beings are we, not this crude matter."
- Yoda

Please list any major surgeries:

Were there any complications? Describe:

List any major accidents:

Please indicate painful or distressed areas:

Age of Menarch (First Menses)?

Please note symptoms you have experienced during menses:

	Menarch-19	Age 20-29	Age 30-39	Age 40+
Used birth control				
Pain/Cramping				
Moodiness				
Breast tenderness				
Clots				
Irregular period				

	Menarch-19	Age 20-29	Age 30-39	Age 40+
Short duration				
Long duration				
Food cravings				
Hot flashes				
Other				

How does hormonal birth control such as the pill effect you?

- ☐ More regular menses
- ☐ Fewer PMS symptoms
- ☐ Mood swings
- ☐ Weight gain
- ☐ Change in cup size
- ☐ Water retention
- ☐ Reduced libido
- ☐ Breast tenderness
- ☐ Other ______________________

Did your menses change after having children?
☐ Yes ☐ No

Acupuncture is a choice method for correcting a baby's position in the 34th week, and also for inducing birth naturally.

Are you using birth control now? ☐ Yes ☐ No
If so, which method? ______________________

Please detail your birth control history:

Type	For how long?

Are you currently pregnant? ☐ Yes ☐ No

Are you trying to get pregnant? ☐ Yes ☐ No

Date of your last menses: ______________________

Please detail your previous births:

Year	Delivery, Miscarriage, or Other	Natural or C-Section	Premature?	Complications?

If you have house mates, please describe them:

Relationship	Age	Health

Do you look forward to coming home at the end of the day?

"No man is an Island, entire of itself; every man is a piece of the Continent, a part of the main; if a clod be washed away by the sea, Europe is the less, as well as if a promontory were, as well as if a manor of thy friends or of thine own were; any man's death diminishes me, because I am involved in Mankind..."

- John Donne

What kinds of emotion do you experience and how often?	Never	Rarely	Sometimes	Frequently
Relaxed				
Stressed out				
Flustered				
Angry				
Sad				
Depressed				
Fatigued				
Low appetite				
Poor sleep				
Weight loss				
Thoughts of self harm				
Numb				
Joyful				

	Never	Rarely	Sometimes	Frequently
Anxiety				
Heart palpitations (racing, skipping a beat, disturbingly strong beats)				
Spontaneous sweating				
Panic attacks				
Other anxiety				
Other:				

The greatest mistake in the treatment of diseases is that there are physicians for the body and physicians for the soul, although the two cannot be separated.

- Plato

What do you do to blow off steam?

What do you do to have fun?

Are there stressors at home? ☐ Mild ☐ Moderate ☐ Severe

Did any of the following events happen in the last 6 months to a year?

	Death of a spouse or loved one
	Divorce/Separation
	Jail term
	Death of close family member
	Personal injury or illness
	Marriage
	Fired from work
	Retirement
	Change in family member's health
	Pregnancy
	Sex difficulties
	Death of a close friend
	Addition to family
	Business readjustment
	Change in financial status
	Change in number of family gatherings
	Change in eating habits
	Vacation
	Christmas / Holiday season
	Minor violations of law

	Change in number of marital arguments
	Change to a different line of work
	Mortgage or loan over $10,000
	Mortgage or loan under $10,000
	Foreclosure on loan or mortgage
	Change in work responsibilities
	Trouble with family member or in-law
	Outstanding personal achievement
	Spouse begins or starts work
	Starting or finishing school
	Change in living conditions
	Change in sleep habits
	Revision of personal habits
	Change in church activities
	Change in social activities
	Large amounts of debt (credit card, student loan, mortgage
	Other:

Do you know any excellent health practitioners that you would like to recommend to others?

Name	Specialty	Contact number

"Experience has taught us that we have only one enduring weapon in our struggle against mental illness: the emotional discovery and emotional acceptance of the truth in the individual and unique history of our childhood."

- Alice Miller, Ph.D.

Adverse Childhood Experience (ACE Study) Questionnaire

While you were growing up, during your first 18 years of life:

1. Did a parent or other adult in the household **often** …
   Swear at you, insult you, put you down, or humiliate you?
   or Act in a way that made you afraid that you might be physically hurt? ☐ Yes ☐ No

2. Did a parent or other adult in the household **often** …
   Push, grab, slap, or throw something at you?
   or Ever hit you so hard that you had marks or were injured? ☐ Yes ☐ No

3. Did an adult or person at least 5 years older than you **ever**…
   Touch or fondle you or have you touch their body in a sexual way?
   or Try to or actually have oral, anal, or vaginal sex with you? ☐ Yes ☐ No

4. Did you **often** feel that …
   No one in your family loved you or thought you were important or special?
   or Your family didn't look out for each other, feel close to each other, or support each other? ☐ Yes ☐ No

5. Did you **often** feel that …
   You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you?
   or Your parents were too drunk or high to take care of you or take you to the doctor if you needed it? ☐ Yes ☐ No

6. Were your parents **ever** separated or divorced? ☐ Yes ☐ No

7. Was your mother or stepmother:
   Often pushed, grabbed, slapped, or had something thrown at her?
   or **Sometimes or often** kicked, bitten, hit with a fist, or hit with something hard?
   or **Ever** repeatedly hit over at least a few minutes or threatened with a gun or knife? ☐ Yes ☐ No

8. Did you live with anyone who was a problem drinker or alcoholic or who used street drugs? ☐ Yes ☐ No

9. Was a household member depressed or mentally ill or did a household member attempt suicide? ☐ Yes ☐ No

10. Did a household member go to prison? ☐ Yes ☐ No