paradigm acupuncture

Acupuncture For Wellness

Patient Questionnaire

Complete this document thoroughly. Some questions may seem unrelated to your condition, but may affect your diagnosis and treatment. All information is confidential. This form should accompany you to your appointment.

Date ____ / ____ / ____	**Last Name**	**First Name**	**Gender** ☐ **M** ☐ **F** ☐ **TG**	**Age**

Social Security # — —	Date of Birth ____ / ____ / ____	Relationship Status *check one* ☐ **Married** ☐ **Single** ☐ **Committed Rltnshp** ☐ **Separated** ☐ **Divorced**

Home Address	City	State	Zip
Phone (daytime) – **Home Work Mobile** *circle one*	Alternate Phone - **Home Work Mobile** *circle one*		
Email address			
Who may we contact in the event of an emergency?	Emergency contact phone		

Indicate Current Occupation(s)	**How long at this job?**

Chief Complaint #1:

Primary reason for your visit? _____

How long have you had this issue? ☐ <1 month ☐ 1-6 mos ☐ 6-12 mos ☐ >12 mos

Are you being seen by another healthcare practitioner for this issue? ☐ **Yes** ☐ **No**

☐ Physician/M.D. ☐ Chiropractor ☐ Naturopath ☐ Homeopath ☐ Other: _____

Are you receiving other treatments for this (OTC meds/prescription meds, physical therapy, etc.)?

If yes, describe_____

Chief Complaint #2:

Is there another issue for which you are seeking treatment? _____

How long have you had this issue? <1 month 1-6 mos 6-12 mos >12 mos

Are you being seen by another healthcare practitioner for this issue? ☐ **Yes** ☐ **No**

☐ Physician/M.D. ☐ Chiropractor ☐ Naturopath ☐ Homeopath ☐ Other: _____

Are you receiving other treatments for this (OTC meds/prescription meds, physical therapy, etc.)?

If yes, describe_____

Personal Health Inventory:

Please put a check mark (☑) by the symptoms that you are currently experiencing.
Place a star (★) next to the ones you have noticed within the last six months.

Qi, Blood, Yin, Yang
- ☐ Anxiety
- ☐ Catches colds easily/frequently
- ☐ Chest pain travels to shoulder
- ☐ Cold feet
- ☐ Cold hands
- ☐ Difficulty concentrating
- ☐ Dizziness
- ☐ Dream disturbed sleep
- ☐ Dry skin
- ☐ Fatigue
- ☐ Afternoon sluggishness
- ☐ Afternoon fever or hot flushes
- ☐ General body weakness
- ☐ Heat in hands/feet/chest
- ☐ Mental confusion
- ☐ Night sweats
- ☐ Palpitations
- ☐ Restlessness
- ☐ Sores on tongue tip
- ☐ Speech problems
- ☐ Sweats easily
- ☐ Lack of sweating
- ☐ Thirst, at night
- ☐ Feels worse after exercise
- ☐ Floaters in the eyes
- ☐ Generally runs cold
- ☐ Generally runs hot
- ☐ Masses or lumps

Lung Function
- ☐ Allergies
- ☐ Chills alternating w/ fever
- ☐ Dry cough
- ☐ Cough w/ phlegm
  Color: _____
- ☐ Difficulty breathing
- ☐ Dry mouth, nose, throat
- ☐ Body aches
- ☐ Headaches
- ☐ Nasal discharge
- ☐ Nose bleeds
- ☐ Shortness of breath
- ☐ Sinus congestion
- ☐ Sneezing
- ☐ Sore throat
- ☐ Stiff neck/shoulders

Spleen Function
- ☐ Chest congestion
- ☐ Diarrhea
- ☐ Eating disorders
- ☐ Fatigue after eating
- ☐ Gas
- ☐ General body heaviness
- ☐ Hemorrhoids
- ☐ Over-thinking, worry
- ☐ Loose stools
- ☐ Undigested food in stool
- ☐ Low appetite
- ☐ Mental sluggishness
- ☐ Nausea
- ☐ Prolapsed organ(s)
- ☐ Swollen feet
- ☐ Swollen hands
- ☐ Bruise easily

Stomach Function
- ☐ Acid reflux
- ☐ Bad breath
- ☐ Belching
- ☐ Bleeding, swollen gums
- ☐ Burning sensation after eating
- ☐ Heartburn
- ☐ Large appetite
- ☐ Mouth sores
- ☐ Stomach pain
- ☐ Vomiting

Heart Function
- ☐ Chest pain
- ☐ Edema
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Insomnia:
  - ☐ Difficulty falling asleep
  - ☐ Difficult staying asleep
  - ☐ Waking early
  - ☐ Waking unrested
- ☐ Palpitations
- ☐ Stroke
- ☐ Varicose veins

Liver/Gallbladder Function
- ☐ Bitter taste in mouth
- ☐ Blood shot eyes
- ☐ Blurred vision
- ☐ Chest pain
- ☐ Convulsions
- ☐ Alternating diarrhea/constipation
- ☐ Dry stool
- ☐ Difficulty swallowing
- ☐ Dry eyes
- ☐ Feeling of lump in throat
- ☐ Headache at top of head
- ☐ Hot flashes
- ☐ Muscles spasms, cramping
- ☐ Hand/feet numbness
- ☐ High-pitch ringing in ears
- ☐ Rib cage pain
- ☐ Seizures
- ☐ Skin rashes
- ☐ Tight feeling in chest
- ☐ TMJ or locked jaw
- ☐ Easily angered
- ☐ Feel better after exercise
- ☐ Depression
- ☐ Inability to make decisions

Kidney/Bladder Function
- ☐ Frequent urination
- ☐ Scanty urination
  Urine color: _____
- ☐ Low sex drive
- ☐ High sex drive
- ☐ Joint pain
- ☐ Loss of bladder control
- ☐ Loose teeth
- ☐ Low back pain/weakness
- ☐ Memory problems
- ☐ Night blindness or low vision
- ☐ Low-pitch ringing in ears
- ☐ Sore, cold, weak knees
- ☐ Frequent night-time urination
- ☐ Hair loss, thinning
- ☐ Kidney stones
- ☐ Bladder infections
- ☐ Fearful, easily startled

For Pain Patients Only:

Indicate if you have had any of the following signs or symptoms within the past 6 months *(check all that apply)*

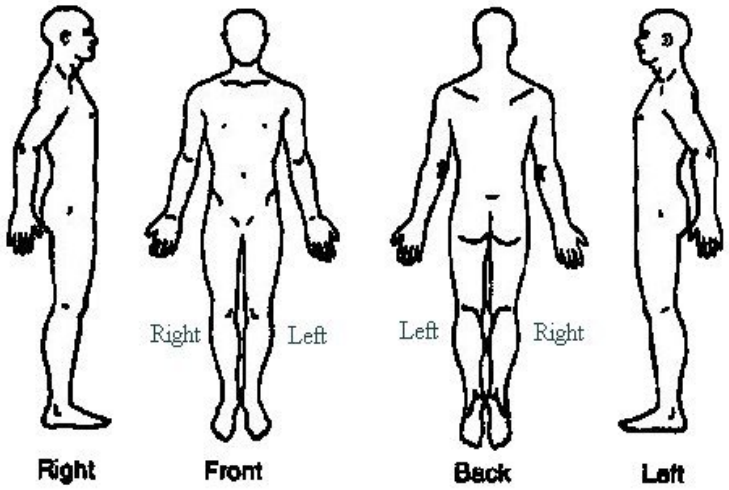
Type of Pain:

Muscle Cramps	☐ Yes	☐ No
Joint Swelling	☐ Yes	☐ No
Muscle Pain	☐ Yes	☐ No
Tendonitis	☐ Yes	☐ No
Arthritis	☐ Yes	☐ No
Bursitis	☐ Yes	☐ No

Quality:

Sharp/stabbing	☐ Yes	☐ No
Burning	☐ Yes	☐ No
Aching/dull	☐ Yes	☐ No
Fixed	☐ Yes	☐ No
Radiating	☐ Yes	☐ No
Numbness	☐ Yes	☐ No
Tingling	☐ Yes	☐ No
Worse with cold	☐ Yes	☐ No
Worse with heat	☐ Yes	☐ No
Other:_____	☐ Yes	☐ No

Please mark an 'X' for problem areas on diagram



Prior Diagnostic History:

Have you ever been diagnosed by a physician with any of the following *(please check all that apply)*

Anorexia/Bulimia	☐**Yes**	Spinal cord dysfunction	☐**Yes**
Emotional *disorders (anxiety, panic attacks, Depression)*	☐**Yes**	Heart Attack	☐**Yes**
Arthritis	☐**Yes**	Sleep apnea	☐**Yes**
Asthma	☐**Yes**	Osteoporosis	☐**Yes**
Autoimmune Disorders	☐**Yes**	Polycystic Ovarian Syndrome	☐**Yes**
Bleeding Disorders	☐**Yes**	Recurrent Infections	☐**Yes**
Cancer/malignancy	☐**Yes**	Restless Leg Syndrome	☐**Yes**
Cancer/malignancy *(describe below)*	☐**Yes**	Restless Leg Syndrome	☐**Yes**
COPD (Emphysema)	☐**Yes**	Skin disorders *(eczema, Psoriasis, acne)*	☐**Yes**
Endometriosis	☐**Yes**	Mumps	☐**Yes**
Fibromyalgia	☐**Yes**	Measles	☐**Yes**
Gallstones	☐**Yes**	Rubella	☐**Yes**
GERD (Acid reflux)	☐**Yes**	Polio	☐**Yes**
Anemia	☐**Yes**	Chicken Pox	☐**Yes**
Hepatitis	☐**Yes**	Childhood ear infections	☐**Yes**
Hypertension	☐**Yes**	Lyme Disease	☐**Yes**
Hyperthyroidism	☐**Yes**	Recurrent childhood infections *(describe below)*	☐**Yes**
Hypotension	☐**Yes**	Irritable Bowel Syndrome (IBS)	☐**Yes**
Hypothyroidism	☐**Yes**	Diabetes (Type I or II)	☐**Yes**
Inflammatory Bowel *Disease (Crohn's, Colitis)*	☐**Yes**	Gallstones	☐**Yes**
Eye disorders	☐**Yes**	Kidney Stones	☐**Yes**

Tobacco Use History

Have you ever smoked (cigarettes, pipes or cigars) or chewed tobacco?	☐**Yes** ☐**No**
Do you still smoke or chew tobacco?	☐**Yes** ☐**No**

Alcohol Use History

Do you now, or did you once, regularly drink alcohol?	☐**Yes** ☐**No**
How often *(indicate number of days per week)*	

List all medications you are currently taking. Include over-the-counter, herbal medicines, and vitamins.

Medication Name	Dose	Last taken	Medication Name	Dose	Last Taken

Do you have allergies? If so, list here	

If you've traveled in the past 12 months, list destinations here	Month(s) & Year(s) *(i.e. August, 2008)*

Have you ever been exposed to known cancer causing agents or inhalation hazards? *Examples: asbestos, paints, aniline dyes, chemicals, silica, mold, etc.*	☐ **Yes** ☐**No**

For Female Patients Only:

	Response
Have you ever been pregnant?	☐ Yes ☐ No
# of children *(specify here)*	
Age at onset of menstruation	
Average length of cycle *(e.g. 28 days)* Length of period *(e.g. 3-4 days)*	
Age of onset of menopause (if applicable)	
Have you ever used hormone replacement therapy?	☐Yes ☐No
Have you ever had, or do you have, and IUD (intrauterine device)?	☐Yes ☐No
Are you currently on birth control?	☐Yes ☐No