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This is a CONFIDENTIAL questionnaire to help 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_____Date _____

Gender _____ Age_____ Birthdate_____

Address_____

City_____State _____Zip_____

Home Phone_____Work Phone_____

Wireless Phone_____

Email_____

If under 18, person responsible for your account_____

Emergency Contact: Name_____
Emergency Contact Phone:_____

Occupation _____
Hobbies _____
Living situation _____
How did you hear about me?_____

Have you had acupuncture therapy before? How was it?_____
_____

What would you like to achieve with acupuncture treatment?_____

_____

_____

**Please CIRCLE 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 B/C HIV/AIDS High Blood Pressure Seizures Blood-Thinning Medication Pacemaker Current Pregnancy

**Please indicate the use and frequency of the following:**

Coffee _____Soda _____ Tea _____ Water _____

Alcohol_____

Recreational drugs _____

Tobacco (include history)_____

Exercise _____

Name and phone number of primary care physician: _____

_____

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

Medication & Dosage (incl. Supplements) Reason / How long

_____

_____

_____

_____

_____

_____

## Health History

Please list your health concerns in order of priority:

1. _____

2. _____

3. _____

Please give answers about your primary complaint: When did it start?

What was happening in your life then?

What other forms of treatment have you sought?

What helps your condition?

What aggravates your condition?

How severe is it? Does it interfere with your daily life?

Is it worse or better at a particular time of day?

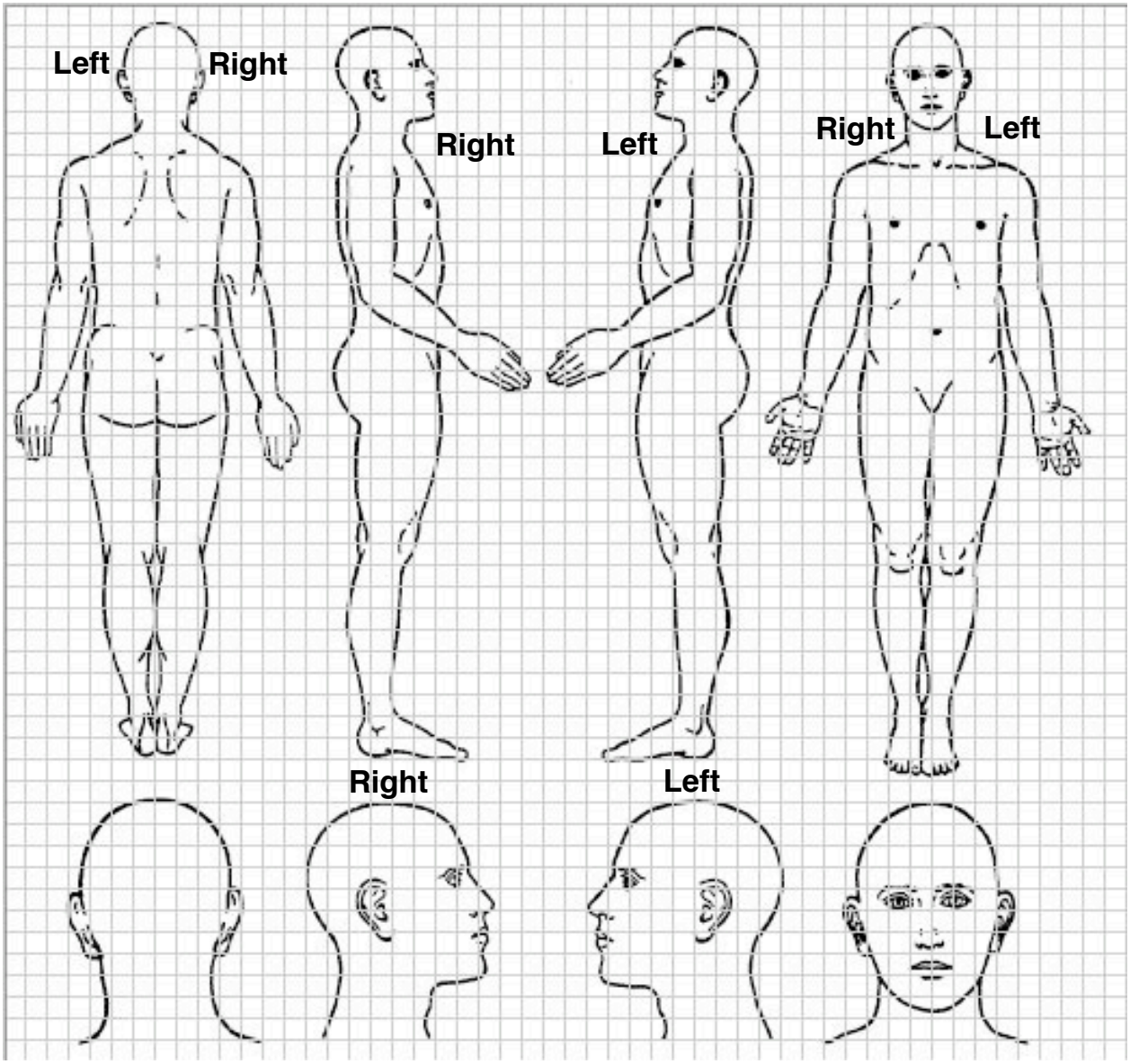
Please list any surgeries or major health incidents (accidents, etc.) in your life

Childhood illnesses

Adult illnesses

What do you believe is causing your most important health concerns?

**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

On a scale of 0-10, 0 being no pain, and 10 being the worst pain imaginable, how do you feel?

_____

**Family History**

**(indicate age at death, circled, if deceased)**

| | Mother | Father | Partner | Siblings / Children | |
|---|---|---|---|---|---|
| **Age** | | | | | |
| **diabetes** | | | | | |
| **tuberculosis** | | | | | |
| **heart disease** | | | | | |
| **high/low BP** | | | | | |
| **stroke** | | | | | |
| **kidney disease** | | | | | |
| **cancer** | | | | | |
| **arthritis** | | | | | |
| **anemia** | | | | | |
| **headaches** | | | | | |
| **mental illness** | | | | | |
| **neurological problems** | | | | | |
| **other issues** | | | | | |

**General:**

Height _____Weight _____Recent weight changes _____

Energy level 1-10___Do you tend to feel hot or cold compared to everyone else?_____

**Nutrition:**

What is your diet like? Do you have any allergies or sensitivities that you know about?

_____

_____

breakfast_____

lunch_____

dinner_____

snacks_____

## For Women

Age of first period _____ Date of last period _____
Are you currently experiencing any gynecological symptoms or problems?___
Are you currently sexually active?____Partner(s) is/are __Male __Female
If sexually active, do you perform safe sex practices?_____
Any problems with sexual desire or function?_____
History of sexually transmitted diseases?_____
Number of pregnancies?___Births?_____Abortions?_____Miscarriages?____
Any complications or female surgeries _____
Date of last Pap Smear?_____Abnormal Pap?_____P_____
How frequent do you have a gyn exam/ pap smears? _____ Any cervical cancer history? _____if yes, when:_____
Any ovarian cancer history? _____if yes, when:_____
Do you perform regular breast self exams? ___yes _no
If menopausal or perimenopausal: List symptoms and concerns:_____
When regular periods stopped?_____
Any personal history of breast cancer?_____
Number of days between periods (your cycle) _____ Number of days of flow _____
Discharge (describe) _____

Circle if you have/ have had the following: PMS - swollen breasts - uterine fibroids - PID endometriosis - ovarian cysts - polycystic ovary syndrome (PCOS) - fibrocystic breasts

| **Color of flow:** | **Amount** | **Pain and cramping:** |
|---|---|---|
| _ pale/light red | _ spotting | _ None |
| _ red | _ light | |
| _ bright red | _ even throughout | _ before flow |
| _ dark red | _ moderate | _ after flow |
| _ brown | _ heavy | _ during flow |
| _ clots | | _ mild |
| _ severe | | |

## For Men

Are you currently sexually active?_____Partner(s) is/are __Male __Female
If sexually active, do you perform safe sex practices?_____
History of sexually transmitted diseases ?_____
Date of last prostate exam? _____
Trouble with sexual function/libido?_____If yes, explain: _____

**CIRCLE any current complaint and <u>UNDERLINE</u> any past complaints, then provide details on the line below.**

**Sleep:**

Amount per night?_____Fall asleep easily? _____Wake easily during the night?_____

If so, is it to urinate? _____ If wake, fall back asleep easily? _____

Wake easily?_____Feel rested in morning? _____Sleep propped up? _____

Vivid dreams Nightmares Naps needed Night sweats /chills Painful to lie down Apnea

**Psychological:**

Depression Anger Anxiety Stress Irritability Other emotional upset _____

**Neurological:**

Headache Migraine Head injury Loss of Consciousness Stroke

Fainting/Dizziness Blackout Seizures Paralysis Local weakness Numbness

Tingling Tremors Difficulty thinking/ confusion Difficulty with memory

**Skin:**

Rashes Lumps Itching Dryness Slow healing Easy / unexplained bruising
Hair loss Color change Nail problems _____

**Eyes:**

Last eye exam _____

Glasses/ Contact lenses Pain Redness Tearing Double Vision Glaucoma Cateract

**Ears:**

Hearing problems Tinnitus Vertigo Balance Earaches Infection Discharge

**Nose & Sinus:**

Sinus congestion Nose running Hay fever/ allergies Nosebleeds Loss of smell

**Mouth & Throat**:

Last dental exam _____

Bleeding gums Sore tongue Frequent sore throat Speech disorder Chronic halitosis

**Neck:**

Lumps Swollen glands Goiter Neck pain

**Breasts:**

Lumps Tenderness Nipple Discharge Change in size/shape

**Respiratory:**

Last chest X-ray_____Sputum (color, quantity): _

Cough Difficulty breathing Shortness of breath Wheezing Asthma Bronchitis

Emphysema Pneumonia Tuberculosis Pleurisy

**Cardiac:**

Chest pain Palpitations Lightheaded / dizziness Heart Attack High /low blood pressure

Heart murmur Edema

**Gastrointestional:**

Low appetite Excess hunger Nausea Vomiting Difficulty swallowing Gastric pain

Abdominal pain Constipation Diarrhea Food allergies IBS Excess belching / gas

Bowel incontinence Rectal bleeding Indigestion Heartburn / Reflux Hemorrhoids

Gall bladder disease Gall stones Jaundice Liver disease Hepatitis

Freq of bowel movements: _____Color _____

Formed / loose / soft / hard Recent change in BM _____

**Urinary:**

Frequency_____Color _____

Cloudy Bloody Frequent urination At night Painful Burning Urgency Hesitancy

Trouble stopping Incontinence Urinary tract infection Kidney stones

**Musculoskeletal:**

Pain Stiffness Swelling Redness Weakness Limited range of motion Arthritis Gout

Neck Shoulders Arms Hands Upper back Middle back Lower back Ribs Hips

Legs Knees Ankles Feet

**Peripheral vascular:**

Pain with exercise  Cramps  Hot/cold extremities  Varicose veins

**Endocrine:**

Thyroid disease  Heat/cold intolerance  Excess sweating  Diabetes / hypoglycemia

Excess thirst

**Hematologic:**

Anemia  Easy bruising / bleeding  Transfusion history

**Immunity:**

Frequent colds/flus  HIV /AIDS  Autoimmune disease  Exposure to toxins

**Anything else?**

## INFORMED CONSENT

I understand that although all efforts will be made to ensure that my treatment is as painless and side-effect-free as possible, sometimes life is not perfect.

I understand that although the acupuncture needles are sterile, and my skin will be cleaned, there is a small risk of infection.

I understand that there is a risk of bleeding, bruising, or pain with needling.

I understand there are a few serious risks associated with acupuncture, such as pneumothorax (punctured lung) or nerve irritation.

I understand that therapeutic bodywork (medical massage) may result in soreness or bruising.

I understand that there are no guarantees with regard to treatment outcome, and that symptoms may become worse after treatment.

I understand that I am free to withdraw this consent and stop treatments at any time.

With this knowledge, I voluntarily consent to acupuncture, moxibustion, cupping, and therapeutic bodywork, and agree to release Sharon Rose from any liability that may occur in connection with the above procedures, except for failure to perform the procedures with appropriate medical care.

## CANCELLATION POLICY

I understand that if I cannot keep an appointment I need to call as soon as possible. I understand that cancellation within 24 hours of the appointment creates a hardship for both Rose City Acupuncture and for patients who may have wanted that time slot, and that I may be charged a $35 cancellation fee for that appointment.

Date _____

Patient name (printed) _____

Patient signature _____

Parent / Legal Guardian's name (if applicable) _____

Parent / Legal Guardian's signature _____