BLUE PATH
ACUPUNCTURE

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This is a CONFIDENTIAL questionnaire to help us determine the best treatment plan for you. If you have questions, please ask. Thank you.

## Personal Information

Name _____ Date of Birth _____ Height _____ Weight _____ Sex ☐ F ☐ M

Home Address _____ City _____ State _____ Zip _____

Email _____ Primary Phone ( ) _____ Cell/Work Phone ( ) _____

Occupation _____

Marital Status: ☐ Single ☐ Married ☐ Partnered ☐ Divorced ☐ Widowed # of Children _____

Have you received acupuncture therapy before: ☐ Yes ☐ No If yes, when _____

How did you hear about us?

Current Patient _____ Doctor _____ Insurance _____

Advertisement _____ Friend _____ Other _____

Emergency Contact: Name _____ Phone ( ) _____ Relationship _____

## Medical History

List the major health events in your life and the age it occurred. These include both medical and emotional events that have had an impact on you. (Some examples are a childhood illness, switching schools, parent's divorce, abusive relationships, death of a pet, surgeries, hospitalizations, pregnancy terminations, times of extreme stress, etc)

List the reasons the alleviation of your symptoms will enhance your life (How do these conditions impair your daily activities?)

Major Complaint(s), in order of **importance** to you: Date began

1. _____
2. _____
3. _____
4. _____

What other forms of treatment have you sought?

Please indicate any significant illnesses you or a blood relative (Grandparent, parent or sibling) have had

| | You | Relative | Date | | You | Relative | Date |
|---|---|---|---|---|---|---|---|
| Alcoholism | ☐ | ☐ | | Coronary Artery Disease | ☐ | ☐ | |
| Allergies | ☐ | ☐ | | Cancer | ☐ | ☐ | |
| Anxiety | ☐ | ☐ | | Depression or mental illness | ☐ | ☐ | |
| Arthritis | ☐ | ☐ | | Diabetes | ☐ | ☐ | |
| Asthma | ☐ | ☐ | | Kidney disorders | ☐ | ☐ | |
| Elevated cholesterol levels | ☐ | ☐ | | Rheumatic Fever | ☐ | ☐ | |
| Heart Disease | ☐ | ☐ | | Seizures | ☐ | ☐ | |
| Hepatitis ☐ A ☐ B ☐ C | ☐ | ☐ | | Thyroid disorders | ☐ | ☐ | |
| High Blood Pressure | ☐ | ☐ | | Tobacco | ☐ | ☐ | |
| Infectious Diseases | ☐ | ☐ | | Tuberculosis | ☐ | ☐ | |
| | | | | Other | | | |

Sexually Transmitted Diseases: ☐ Gonorrhea ☐ Syphilis ☐ HIV ☐ HPV ☐ Chlamydia ☐ Herpes

**Medications** - Please list all prescription medications you use. Include those which you may only use occasionally. Remember inhalers, eye drops, nose sprays, and topical creams.

| Prescription Name | Purpose | How Long | Dosage | How Often | Last Dose |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

**Supplements-** Please list all supplements you use

| Supplement Name | Purpose |
|---|---|
| | |
| | |
| | |
| | |
| | |

Check the boxes if any of the following statements are true:

☐ I have known allergies

☐ I am taking Coumadin/warfarin

☐ I have a pacemaker

☐ I am taking lithium (Eskalith, Lithobid, Lithonate, Lithotabs)

Please indicate the use and frequency of the following:

| | Yes | No | How Much | | Yes | No | How Much |
|---|---|---|---|---|---|---|---|
| Coffee/black tea | ☐ | ☐ | | Alcohol | ☐ | ☐ | |
| Tobacco | ☐ | ☐ | | Soda | ☐ | ☐ | |
| Water | ☐ | ☐ | | Other | ☐ | ☐ | |

Exercise and frequency amount _____

Do you follow a particular diet? _____

List any allergies, food sensitivities or food craving that you have.

List any accidents, surgeries, or hospitalizations (include date).

## FOR WOMEN

Age of 1st period (menarche) _____ Are you pregnant? ☐ Yes ☐ No # of Pregnancies _____

Age of last period (menopause) _____ # of live births _____ # of abortions _____ # of miscarriages _____

Number of days between periods _____ Date of last Gynecologic Exam _____

Number of days of flow _____ Date of last Mammogram _____

Color of flow (light pink to black red) _____ Date of last PAP Smear _____

Clots? ☐ Yes ☐ No Pap Smear ☐ Normal ☐ Abnormal

Have you been diagnosed with: ☐ Fibroids ☐ Fibrocystic Breasts ☐ Endometriosis ☐ Ovarian Cysts ☐ PID Other _____

Current method of contraception _____

Urinary tract infections _____

Pain/itching of genitalia _____

Nature of pain: (indicate before, during, or after menses)

Cramping _____ Aching _____ Consistent _____

Burning _____ Bloating _____ Stabbing _____

Dull _____ Intermittent _____ Bearing Down Sensation _____

Other Symptoms related to menses:

☐ Discharge ☐ Hot Flashes ☐ Night Sweats ☐ Poor Appetite ☐ Decreased Libido

☐ Nausea ☐ Headache ☐ Constipation ☐ Increased Libido ☐ Increased Appetite

☐ Insomnia ☐ Diarrhea ☐ Mood Swings ☐ Swollen Breasts

I understand that I must notify my Acupuncturist if I become pregnant. Initial _____

## FOR MEN

Date of last prostate checkup _____ PSA Results _____ Manual prostate exam results _____

Frequency of Urination: Day Time _____ Night Time _____ Color of urine: ☐ Murky ☐ Clear Odor: _____

Symptoms related to prostate:

- ☐ Prostate Problems
- ☐ Urine Retention
- ☐ Incontinence
- ☐ Delayed Stream
- ☐ Rectal Dysfunction
- ☐ Premature Ejaculation
- ☐ Impotence
- ☐ Increased Libido
- ☐ Testicular Pain
- ☐ Dribbling
- ☐ Groin Pain
- ☐ Back Pain
- ☐ Decreased Libido

Other _____

## SYMPTOM SURVEY (For Everyone)

The following is a list of symptoms that you may or may not ever experience. Please indicate as follows:
No mark = never experience

| | Sometimes | Frequently | | Sometimes | Frequently |
|---|---|---|---|---|---|
| Lack of appetite | ☐ | ☐ | Mind tends to over think issues | ☐ | ☐ |
| Excessive appetite | ☐ | ☐ | Hemorrhoids | ☐ | ☐ |
| Loose stool/diarrhea | ☐ | ☐ | Limbs feel heavy | ☐ | ☐ |
| Constipation | ☐ | ☐ | Easy bruising | ☐ | ☐ |
| Digestive issues | ☐ | ☐ | Bleeds easily | ☐ | ☐ |
| Indigestion | ☐ | ☐ | Weakness | ☐ | ☐ |
| Vomit | ☐ | ☐ | Abdominal distention/bloating | ☐ | ☐ |
| Belch/burp | ☐ | ☐ | Flatulence/gas | ☐ | ☐ |
| Bad breath | ☐ | ☐ | Acne | ☐ | ☐ |
| Abdominal pain | ☐ | ☐ | Diminished sense of taste | ☐ | ☐ |
| Heartburn | ☐ | ☐ | Difficult to get up in the morning | ☐ | ☐ |
| Acid reflux | ☐ | ☐ | Foggy Brain | ☐ | ☐ |

| | Sometimes | Frequently | | Sometimes | Frequently |
|---|---|---|---|---|---|
| Blood in stool | ☐ | ☐ | Chronic sinusitis | ☐ | ☐ |
| Black tarry stool | ☐ | ☐ | Allergies | ☐ | ☐ |
| Cough | ☐ | ☐ | Skin issues | ☐ | ☐ |
| Shortness of breath | ☐ | ☐ | Sweating easily without exertion | ☐ | ☐ |
| Asthma | ☐ | ☐ | Feeble voice | ☐ | ☐ |
| Dry throat/mouth/nose | ☐ | ☐ | Frequent sadness | ☐ | ☐ |
| Tendency to easily catch colds | ☐ | ☐ | Recent grief | ☐ | ☐ |
| Diminished sense of smell | ☐ | ☐ | | | |

| | Sometimes | Frequently | | Sometimes | Frequently |
|---|---|---|---|---|---|
| Low back pain | ☐ | ☐ | Frequent urination | ☐ | ☐ |
| Knee problems | ☐ | ☐ | Frequent urination at night (#times) | ☐ | ☐ |
| Hearing impairment | ☐ | ☐ | Lack of drive or will power | ☐ | ☐ |
| Ear ringing | ☐ | ☐ | Short term memory issues | ☐ | ☐ |
| Kidney stones | ☐ | ☐ | Diminished night vision | ☐ | ☐ |
| Decreased sex drive | ☐ | ☐ | Worsening of symptoms at night | ☐ | ☐ |
| Hair loss | ☐ | ☐ | Night sweating | ☐ | ☐ |
| Graying hair | ☐ | ☐ | Fear | ☐ | ☐ |
| Edema | ☐ | ☐ | Frequently feel cold | ☐ | ☐ |

| | Sometimes | Frequently | | Sometimes | Frequently |
|---|---|---|---|---|---|
| Heart palpitations | ☐ | ☐ | Anxiety | ☐ | ☐ |
| Chest pain | ☐ | ☐ | Easily startled | ☐ | ☐ |
| Insomnia | ☐ | ☐ | Poor memory | ☐ | ☐ |
| Nightmares | ☐ | ☐ | Mouth sores | ☐ | ☐ |

Stress (1-10, 10 being most stress) _____

Fatigue (1-10, 10 being most tired) _____

| | Sometimes | Frequently | | Sometimes | Frequently |
|---|---|---|---|---|---|
| Irritability | ☐ | ☐ | Depression | ☐ | ☐ |
| Jaundice (yellowish eyes or skin) | ☐ | ☐ | Blurry vision | ☐ | ☐ |
| Gallstones | ☐ | ☐ | Dizziness | ☐ | ☐ |
| Light colored stool | ☐ | ☐ | Headaches | ☐ | ☐ |
| Difficulty digesting fats or oils | ☐ | ☐ | Migraines | ☐ | ☐ |
| Difficulty making plans or decisions | ☐ | ☐ | Tight or cracking joints | ☐ | ☐ |
| Easily angered or agitated | ☐ | ☐ | Eye twitch | ☐ | ☐ |
| Twitch or spasm of muscle | ☐ | ☐ | Clench teeth at night | ☐ | ☐ |
| Tight feeling in chest | ☐ | ☐ | Emotional eating | ☐ | ☐ |
| Cold hands and feet | ☐ | ☐ | | | |