Full Moon Acupuncture

Help me provide you with a complete evaluation by taking the time to fill out this questionnaire carefully. All answers are confidential. Please print clearly in ink.

Name: _____ Date: _____

Gender: _____ Pronoun: _____

Address: _____

Telephone: _____ Date of birth: _____ Age: _____

Email: _____

Single Married Separated/Divorced Widowed Partnered

Education/Occupation: _____

Emergency contact: _____ Relation: _____

Emergency contact telephone: _____

Name of physician: * _____

Address of physician: _____

Phone number of physician: _____

Date of last physician appointment: _____

Date of last gynecology exam: _____

Have you ever been treated with acupuncture and/or Chinese herbal medicine before? Yes/ No

* No contact will be made with the physician without your permission.

Lifestyle Habits: For each item, please indicate how much, how many, or how often. Please note if this is current or the date that you quit.

Cigarettes per day: _____ Cannabis per day: _____ Coffee per day: _____

Alcohol per week: _____ Soda per day: _____ Other caffeine per day: _____

What would you like acupuncture to help you with?

_____

_____

_____

Please tell me about major changes in your recent life:

_____

_____

What is going well?

_____

_____

How would you characterize your energy levels on a scale of 1-10. "10" being you have all of the energy you need for your life!!! Upon waking: _____ 2 hours after breakfast

_____ 3-5pm _____ 7-9pm: _____

How do you take care of yourself?

_____

_____

Who or what else is part of your 'wellness plan'?

_____

_____

Medical: Have you ever been hospitalized for a serious medical illness or operation? Please write the most recent ones below: (Do not include normal pregnancies.)

Operation/Illness: Year:

_____

_____

_____

Medicines:

What prescription drugs are you currently taking: For what condition:

_____

_____

_____

_____

_____

Supplements/Herbs: For what condition:

_____

_____

_____

_____

Please circle any symptoms that you are currently experiencing or anything that has been recurring. Please expound as you feel beneficial.

General:

Insomnia
Dreams/ nightmares

Fatigue
Poor memory
Strongly like cold drinks

Strongly like hot drinks

Recent weight loss/gain

Cold hands & feet

Chills
Fever

Head & Neck:

Headaches

Migraines
Stiff neck
Dizziness

Fainting

Swollen glands

Ears Ringing
Hearing loss

Hearing aids

Infections
Earache
Vertigo

Eyes:

Glasses/ contact lenses

Blurred vision
Poor night vision
Spots or floaters

Eye inflammation

Double vision

Glaucoma
Cataracts

Nose, Throat & Mouth:

Sinus infection
Hay fever/ allergies

Frequent sore throat

Difficulty swallowing

Mouth & tongue ulcers

Frequent colds

Nosebleed
Dry nose
Nasal congestion

Loss of voice
Thirst
Excessive phlegm

TMJ
Facial pain
Gum problems
Dry mouth

Skin:

Hives
Rashes
Eczema/ psoriasis
Night sweating
Excessive sweating
Dry skin
Bruise easily
Changes in moles, lumps

Itching

Respiratory:

Difficulty breathing
Difficulty breathing when reclining

Wheezing
Asthma
Chronic cough
Wet cough
Dry cough
Coughing up phlegm
Coughing up blood
Shortness of breath
Tight chest
Pneumonia

Cardiovascular:

High blood pressure

Low blood pressure

Chest pain or tightness

Palpitation

Rapid heart beat

Irregular heart beat

Poor circulation

Swollen ankles

Phlebitis

Anemia
History of heart attack

Gastrointestinal:

Nausea

Indigestion

Stomach pain

Diarrhea

Constipation

Poor appetite

Excessive hunger

Vomiting

Gas

Hiccups
Acid regurgitation

Bloating
Bad breath

Laxative use

Bloody stool

Hemorrhoids

Anal Fissures

Musculoskeletal:

Joint pain/disorder

Sore muscles

Weak muscles

Difficulty walking

Neck/shoulder pain

Upper back pain

Lower back pain

Rib pain

Limited range of motion

Other (describe):

Neurological:

Seizures
Tremors
Numbness or tingling Pain (describe)

Paralysis
Poor coordination

Other (describe):

Mental/Emotional:

Depression
Mood swings
Irritability

Difficulty relaxing
Loneliness
Sensitive
Shy
Cry often
Worry a lot

Compulsive behaviors

Difficulty focusing
Hopeless outlook
Suicidal thoughts
Lose temper
Frustration

Urinary:

Pain on urination
Frequent urination

Urgent urination

Blood in urine

Unable to hold urine

Incomplete urination

Bedwetting

Wake to urinate

Increased libido

Decreased libido

Kidney stones

Gynecology:

Age of first menses

Typical length of cycle

How would you describe your flow? Light, Medium, Heavy

Do you experience cramping? Before or during bleeding or, both

Currently pregnant

__ # of Pregnancies

Miscarriages
Abortions

Menopause
Hormone replacement therapy

Irregular periods
Menstrual cramps

Excessive blood flow
Menstrual blood clots
Breast tenderness
Abnormal pap smear
Vaginal infections
Vaginal pain/itching
Uterine fibroids
Endometriosis
Breast lumps, cysts

Infection Screening (circle self and/or partner)

HIV risks: self or partner
TB: self or household

Hepatitis risk: self or partner

History of sexually transmitted disease: self or partner

Gonorrhea: self or partner

Chlamydia: self or partner

Syphilis: self or partner

Genital warts: self or partner

Herpes: oral/genital: self or partner

Is there anything else you would like me to know regarding your history or well being?

_____

_____

_____

Signature:_____

Date: _____