

ACUPUNCTUREWORKZ NEW PATIENT QUESTIONNAIRE

Important: Complete this document as thoroughly as possible. Some of the questions that follow may seem unrelated to your condition, but they may play a major role in diagnosis and treatment.

All information is strictly confidential.

I. General Patient Information

Date: Day: _____ Month: _____ 2011 Name: _____

Address: _____ City, State, Zip Code: _____

Home Phone: (____) _____ Work: (____) _____ Cell: (____) _____ E-Mail: _____@_____.

May we contact you by e-mail to follow up on your treatment? Yes No

Would you like to receive our monthly newsletter via e-mail? Yes No

Age: _____ Date of Birth: Day: _____ Month: _____ Year: _____

In Case of Emergency, Contact: _____ Phone No.:(____) _____

Gender: M F Height: _____' _____" Weight: _____ lbs Occupation: _____

How did you hear about our office? _____

Are you military or family member? Yes No Who is your health insurance carrier? _____

May we file health insurance claims for you? Yes No

Major Complaint(s), in order of significance to you:

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

Medications (prescribed and over-the-counter): _____

II. Patient Medical History

Hospital Stays: _____

Recent medical tests? _____ Recent Surgeries? _____

Check any you have had in the past or present:

- | | | | |
|---|--|--|---|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Allergies | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> CVA (stroke) | <input type="checkbox"/> Vein condition | <input type="checkbox"/> Thyroid disorder |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Emphysema/COPD |
| <input type="checkbox"/> Jaundice | <input type="checkbox"/> Cancer | <input type="checkbox"/> Bleeding tendency | <input type="checkbox"/> Fibromyalgia |
| <input type="checkbox"/> STD | <input type="checkbox"/> Measles | <input type="checkbox"/> Chicken pox | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> Meningitis | <input type="checkbox"/> HIV | <input type="checkbox"/> Polio | <input type="checkbox"/> Mononucleosis |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> High fever | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Multiple Sclerosis |
| <input type="checkbox"/> Paralysis | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Migraines | <input type="checkbox"/> High blood pressure |
| <input type="checkbox"/> Other lung illnesses | <input type="checkbox"/> Other liver illnesses | <input type="checkbox"/> Other heart illnesses | <input type="checkbox"/> Other kidney illnesses |

Other: _____

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(revised 24 Mar 2011)

16350 Blanco Rd. #129

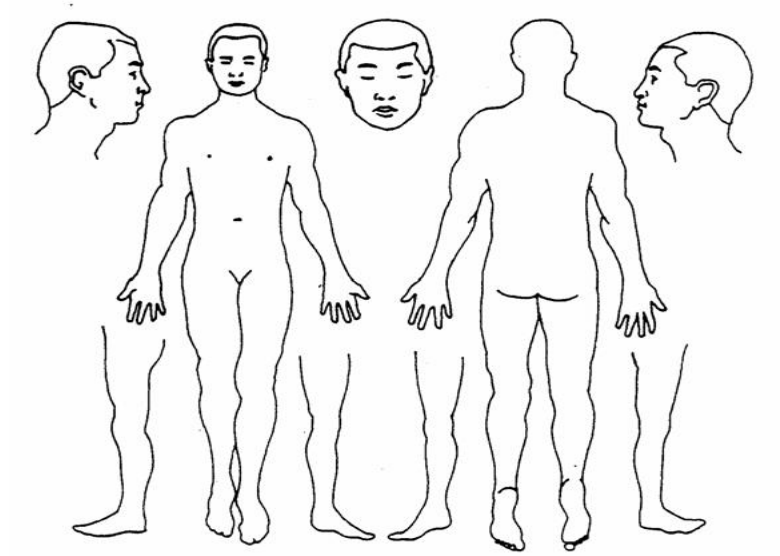
San Antonio, TX 78232

Name: _____ Date of Birth: _____

III. Patient Profile

Please clearly mark any areas of pain:

Is the pain: _____



- | | | |
|-----------------------------------|---------------------------------------|---------------------------------|
| <input type="checkbox"/> Sharp | <input type="checkbox"/> Burning | <input type="checkbox"/> Aching |
| <input type="checkbox"/> Cramping | <input type="checkbox"/> Dull | <input type="checkbox"/> Moving |
| <input type="checkbox"/> Fixed | <input type="checkbox"/> Other: _____ | |

Do the following lessen the pain?

- | | | |
|-----------------------------------|---------------------------------------|-------------------------------|
| <input type="checkbox"/> Pressure | <input type="checkbox"/> Cold | <input type="checkbox"/> Heat |
| <input type="checkbox"/> Exercise | <input type="checkbox"/> Other: _____ | |

Do the following worsen the pain?

- | | | |
|-----------------------------------|---------------------------------------|-------------------------------|
| <input type="checkbox"/> Pressure | <input type="checkbox"/> Cold | <input type="checkbox"/> Heat |
| <input type="checkbox"/> Exercise | <input type="checkbox"/> Other: _____ | |

Please check the following that currently pertain to you (if you have symptoms in the following categories, it indicates that you have a problem with that organ's function):

Overall Temperature:

- | | |
|---|--|
| <input type="checkbox"/> Cold hands | <input type="checkbox"/> Cold fingers |
| <input type="checkbox"/> Cold feet | <input type="checkbox"/> Cold toes |
| <input type="checkbox"/> Sweaty hands | <input type="checkbox"/> Sweaty feet |
| <input type="checkbox"/> Hot body temperature (sensation) | <input type="checkbox"/> Cold body temperature (sensation) |
| <input type="checkbox"/> Afternoon flushes | <input type="checkbox"/> Night sweats |
| <input type="checkbox"/> Heat in the hands, feet, and chest | <input type="checkbox"/> Hot flashes any time of the day |
| <input type="checkbox"/> Thirsty | <input type="checkbox"/> Perspire easily |
| <input type="checkbox"/> Lack of perspiration | <input type="checkbox"/> Take water to bed |

Overall energy:

- | | |
|--|--|
| <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Difficulty keeping eyes open in the daytime |
| <input type="checkbox"/> General weakness | <input type="checkbox"/> Easily catch colds |
| <input type="checkbox"/> Low energy | <input type="checkbox"/> Feel worse after exercise |

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Overall blood:

- Dizziness
- See floating black spots

- Palpitations
- Anxiety
- Sores on the tip of the tongue
- Restlessness
- Mental confusion
- Chest pain traveling to shoulder
- Frequent dreams
- Wake unrefreshed
- Drink coffee (# of cups per week: _____)

- Nasal Discharge (Color: _____)
- Cough
- Nose Bleeds
- Sinus Congestion
- Dry mouth
- Dry throat
- Dry Nose
- Dry Skin
- Allergies (To what? _____)
- Alternating fever and chills
- Sneezing
- Headache (Location: _____)
- Overall achy feeling in the body
- Stiff neck
- Stiff shoulders
- Sore throat
- Difficulty breathing
- Smoke cigarettes (# of cigarettes per day: _____)
- Sadness
- Melancholy

Digestion:

- Low appetite
- Abrupt weight gain
- Abrupt weight loss
- Abdominal bloating
- Abdominal gas
- Gurgling noise in the stomach
- Fatigue after eating
- Prolapsed organs (which organ? _____)
- Easily bruised
- Hemorrhoids
- Pensive
- Over-thinking
- Worry
- Constipated
- Incomplete
- Loose stools
- Mucous in stools
- Diarrhea
- Blood in stools
- Number of bowel movements daily: _____
- Undigested food in stools

Dampness trapped in the body:

- General sensation of heaviness in the body
- Mental fogginess
- Swollen hands
- Swollen feet
- Swollen joints
- Chest congestion
- Nausea
- Snoring

Stomach:

- Burning sensation after eating
- Large appetite
- Bad breath
- Mouth (canker) sores
- Bleeding, swollen or painful gums
- Heartburn
- Acid regurgitation
- Ulcer (diagnosed)
- Belching
- Hiccups
- Stomach pain
- Vomiting
- Tight sensation in the chest
- Bitter taste in the mouth
- Anger easily
- Frustration
- Depression
- Irritability
- Frequently unable to adapt to stress (What causes the stress? _____)
- Skin rashes
- Tingling sensation

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- Numbness
- Muscle cramping
- Neck tension
- Shoulder tension
- Drink alcohol How much per week? _____
- Recreational drugs How much per week? _____
- High-pitched ringing in the ears
- Gall stones (history or current)
- Muscle spasms
- Lump in the throat
- Limited Range-of-Motion, Neck
- Limited Range-of-Motion, Shoulder

Eyes:

- Itchy
- Hot
- Watery
- Blurry vision
- Near-sighted
- Bloodshot
- Dry
- Gritty
- Decreased night vision
- Far-sighted

Other:

- Frequent cavities
- Sore knees
- Cold sensation in the knees
- Memory problems
- Low-pitched ringing in the ears
- Bladder infections
- Lack of bladder control
- Urination normal
- Urination abnormal
- Easily broken bones
- Weak knees
- Low back pain
- Excessive hair loss
- Kidney stones
- Wake during the night twice or more to urinate
- Easily startled

Libido:

- Normal
- High
- Low

Women only:

- Regular menstrual cycle? Y N
- Number of children: _____
- Age of first menstruation: _____
- Average number of days of flow: _____
- Vaginal discharge
- Pregnant? Y N
- Number of pregnancies: _____
- Age of menopause (if applicable): _____
- Average number of days of entire cycle: _____
- Bleeding between periods

Do you experience any of the following pre-menstrual syndromes?

- nausea
- vomiting
- water retention
- breast swelling
- food cravings
- headaches
- migraines
- breast tenderness
- depression
- irritability
- anxiety
- other emotions: _____
- pain, where? _____

Men only:

- Swollen testes
- Testicular pain
- Impotence
- Premature ejaculation

Patient Signature: _____