17525 Ventura Blvd., Suite # 108 Encino, CA 91316 (818)-817-0049
www.GoldenValleyAcu.com

This is a CONFIDENTIAL questionnaire to help us 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_____Age_____ Date _____

Home Address_____

City_____ State_____ Zip_____

Home Phone_____ Work Phone_____E-mail_____

Birthdate_____ If under 18, person responsible for your account_____

Emergency Contact: Name_____ Contact Phone:_____

Occupation: _____ Gender: _____ Height: _____ Weight: _____

Whom should we thank for referring you to our office? _____

Have you had acupuncture therapy before? □ Yes □ No With Whom? _____

Please indicate 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 □ HIV □ High Blood Pressure □ Seizures □ Pacemaker □ Blood-Thinning Meds □ Pregnancy

Please indicate the use and frequency of the following:

Coffee _____ Soda pop _____Water _____

Alcohol_____ Recreational drugs _____ Tobacco_____

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

Medication	Reason
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Health History

What are the health problems for which you are seeking treatment? _____

_____

_____

How long have you had this condition? _____

What other forms of treatment have you sought? _____

_____

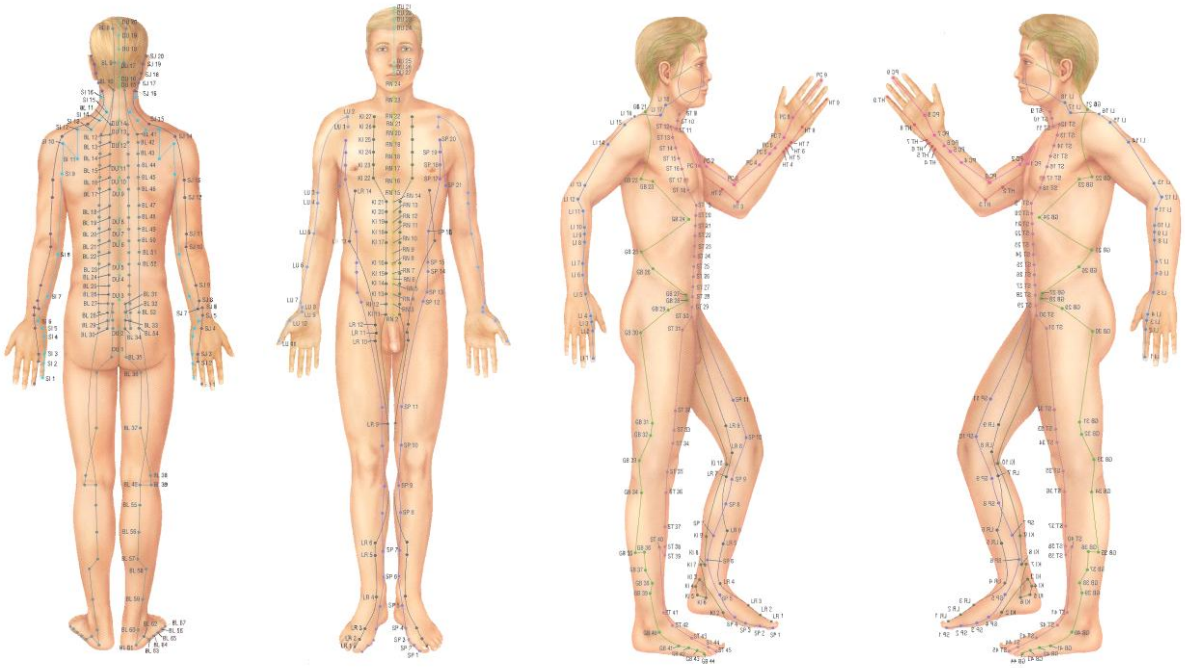
What helps your condition? _____

What aggravates your condition? _____

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

_____

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

What would you like to achieve with acupuncture treatment? _____

_____

Symptom Survey

Please "check" the symptoms or conditions you experience <u>frequently</u>:

__ excessive appetite	__ insomnia	__ cough	__ low back pain
__ eye problems	__ loose stool/diarrhea	__ palpitations	__ shortness of breath
__ knee problems	__ jaundice	__ digestive problems,	__ cold hands and feet
__ decreased sense of smell	__ hearing impairment	__ difficulty digesting oily foods	___indigestion
__ vomiting	__ nightmares	__ nasal problems	__ ear ringing
__ gall stones	__ belching, burping	__ mentally restless	__ skin problems
__ kidney stones	__ light-colored stool	__ heartburn/reflux	__ laughing for no reason
__ claustrophobia	__ decreased sex drive	__ soft or brittle nails	__ stomach bloating
__ chest pains	__ colitis/diverticulitis	__ hair loss	__ easily angered
__ obsession in work,	__ poor memory	__ constipation	__ urinary problems
__ difficulty in relationships, making decisions, etc.		__ lack of appetite	__ sadness
__ hemorrhoids	__ dental problems	__ high cholesterol	__ recent use of antibiotics
__ bitter taste	__ fatigue	__edema	__asthma
__allergies	__dizziness	__ get sick easily	__headaches
__ I usually feel warm	__ I usually feel chilled		

♀For Women

Age of first period _____ Date of last period _____ Number of children _____

Number of days between periods (your cycle) _____Number of days of flow_____

Color of flow:	**Amount of flow:**	**# of pads you use per day:**	**Pain and cramping:**
□ pale/light red	□ spotting	1st day ___	□ No
□ red	□ light	2ND day ___	□ Yes
□ bright red	□ even throughout	3RD day ___	□ before flow □ mild
□ dark red	□ heavy	4th day ___	□ during flow □ moderate
□ dark red/brown	□ clots	+days ___	□ after flow □ severe

Other symptoms related to menses:

□ Discharge	□ PMS	□ Headache	□ Nausea
□ Constipation	□ Diarrhea	□ Swollen Breasts	□ Mood Swings
□ Increased Appetite	□ Decreased Appetite	□ Insomnia	

♀For Women (cont.)

Have you ever been diagnosed with:
□ fibroids □ fibrocystic breasts □ endometriosis □ ovarian cysts □ PID
□ polycystic ovary syndrome □ STD _____

Please indicate if the following pertain to you:

□ Do you have lower back weakness, soreness or pain?

□ Do you have ringing in your ears?

□ Is your hair prematurely gray?

□ Do you have vaginal dryness?

□ Is your mid-cycle cervical mucus scanty or missing?

□ Do you have dark circles under your eyes?

□ Do you have night sweats?

□ Are you prone to hot flashes?

□ Would you describe yourself as "afraid" frequently?

□ Do you have dizziness?

□ Do you have knee problems?

□ Do you have low back pain pre-menstrually?

□ Is your back sore or weak?

□ Are your feet cold, especially at night?

□ Are you typically colder than those around you?

□ Is your libido low?

□ Are you often fearful?

□ Do you wake up at night or early in the morning because you have to urinate?

□ Do you urinate frequently, and is the urine diluted and/or profuse?

□ Do you have early morning loose, urgent stools?

□ Do you have profuse vaginal discharge?

□ Do you feel cold cramps during your period that respond to a heating pad?

□ Are you often fatigued?

□ Do you have poor appetite?

♀For Women (cont.)

- □ Is your energy low after a meal?
- □ Do you feel bloated after eating?
- □ Do you crave sweets?
- □ Do you have loose stools, abdominal pain, or digestive problems?
- □ Are your hands and feet cold?
- □ Are you prone to feeling sluggish?
- □ Are you prone to heaviness or grogginess in the head?
- □ Do you have varicose veins?
- □ Are you prone to worry?
- □ Have you been diagnosed with low blood pressure?
- □ Do you sweat a lot without exerting yourself?
- □ Do you feel dizzy or light-headed, or have visual changes when you stand up fast?
- □ Is your menstruation thin, watery, profuse, or pinkish in color?
- □ Are you more tired around ovulation or menstruation?
- □ Do you ever spot a few days or more before your period comes?
- □ Have you ever been diagnosed with uterine prolapse?
- □ Are your menstrual cramps accompanied by a bearing down sensation in your uterus?
- □ Are you often sick, or do you have allergies?
- □ Have you ever been diagnosed with hypothyroid or anemia?
- □ Do you have hemorrhoids or polyps?
- □ Are your menses scant or late?
- □ Do you have dry, flaky skin?
- □ Are you prone to getting chapped lips?
- □ Are your fingernails or toenails brittle?
- □ Are you losing hair on your head?
- □ Is your hair brittle or dry?
- □ Do you have diminished nighttime vision?

♀For Women (cont.)

- □ Do you get dizzy or light-headed around your period?
- □ Are your lips, the inner side of your lower eyelids, or tongue pale in color?
- □ Is your menstrual flow ever brown or black in color?
- □ Do you feel mid-cycle pain around your ovaries?
- □ Do you have painful, unmovable breast lumps?
- □ Do you experience periodic numbness of your hands and feet, especially at night?
- □ Do you have varicose or spider veins?
- □ Do you have red cherry spots (hemangiomas) on your skin?
- □ Do you have chronic hemorrhoids?
- □ Does your menstrual blood contain clots?
- □ Have you been diagnosed with endometriosis or uterine fibroids?
- □ Do you have piercing or stabbing menstrual cramps?
- □ Do you have dark spots in your eyes?
- □ Have you been diagnosed with any vascular abnormality or blood clotting disorder?
- □ Are you prone to emotional depression?
- □ Are you prone to anger and/or rage?
- □ Do you become irritable premenstrually?
- □ Do you feel bloated or irritable around ovulation?
- □ Does it feel as if your ovulation lasts longer than it should?
- □ Are your breasts sensitive/sore at ovulation?
- □ Do you experience nipple pain or discharge from your nipples?
- □ Do you have a lot of pre-menstrual breast distension or pain?
- □ Do you become bloated pre-menstrually?
- □ Are your pupils usually dilated and large?
- □ Do you have difficulty falling asleep at night?
- □ Do you experience heartburn or wake up with a bitter taste in your mouth
- □ Are your menses painful?

♀For Women (cont.)

- □ Do you feel your menstrual cramps in the external genital area?
- □ Is your menstrual blood thick and dark, or purplish in color?
- □ Do you wake up early in the morning and have trouble getting back to sleep?
- □ Do you have heart palpitations, especially when anxious?
- □ Do you have nightmares?
- □ Do you seem low in spirit or lacking vitality?
- □ Are you prone to agitation or extreme restlessness?
- □ Do you fidget?
- □ Do you sweat excessively, especially on your chest?
- □ Are your mouth and throat usually dry?
- □ Are you often thirsty for cold drinks?
- □ Do you often feel warmer than those around you?
- □ Do you wake up sweating or have hot flashes?
- □ Do you breakout with red acne, especially pre-menstrually?
- □ Do you have a short menstrual cycle?
- □ Do you have vaginal irritation?
- □ Do you feel tired and sluggish after a meal?
- □ Do you have fibrocytic breasts?
- □ Do you have cystic or pustular acne?
- □ Do you have urgent, bright, or foul-smelling stools?
- □ Does your menstrual blood contain stringy tissue or mucus?
- □ Are you prone to yeast infections and vaginal itching?
- □ Are you overweight?
- □ Do you have a wet, slimy tongue?
- □ Does your body feel like a barometer? Can you sense when it will rain?

Fertility Information

# of IVF procedures_____ # of IUI procedures_____

# of pregnancies_____ #of miscarriages_____

# of live births_____

Has a physician diagnosed a difficulty with fertility due to:

□ Female Factor □ Male Factor □ Unexplained

□ Other _____

Conclusion

Please check which services you would be interested in:

□ Chinese herbal medicine □ Therapeutic massage

□ Tai chi □ Qi gong health exercises □ Relaxation techniques □ Nutritional consultation

Cancellation Policy

In order to maintain the integrity of our practice, Golden Valley Acupuncture Center must request that all cancellations be made prior to within 24 hours of your appointment. Failure to provide at least a 24 hour notice or failure to show for an appointment will result in your account being charged for the full price of the visit.*

THANK YOU FOR YOUR UNDERSTANDING.

PRINT NAME: _____

SIGNATURE: _____ DATE: _____

*We do understand that unforeseen circumstances arise,
and for that we will not charge you the first time this situation occurs.