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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? _____

Health History

Please indicate any significant illnesses you or a blood relative (grandparent, parent, or sibling) have had: (marking "yes" does not make you ineligible for treatment, however, it may restrict some treatment modalities):

Illness	You	Your Relative	Illness	You	Your Relative
Cancer	□	□	Diabetes	□	□
Hepatitis	□	□	Heart Disease	□	□
High Blood Pressure	□	□	Seizures	□	□
Rheumatic Fever	□	□	Emotional Disorders	□	□
Infectious Diseases	□	□	Tuberculosis	□	□

Sexually Transmitted Diseases:

□ Gonorrhea □ Syphilis □ HPV □ Chlamydia □ Herpes (Dates_____)

Other Conditions:

□ HIV/AIDS □ Pacemaker □ Blood-Thinning Meds □ Pregnancy (Dates_____)

List any medications and supplements you are currently taking: (Continue on back if necessary)

Medicine	Dosage	Reason	How Long	Prescribed by	Date of Last Checkup

Please indicate the use and frequency of the following:

	Yes	No	How Much		Yes	No	How Much
Coffee/Black Tea	□	□	_____	Tobacco	□	□	_____
Soda Pop	□	□	_____	Alcohol	□	□	_____
Recreational Drugs	□	□	_____	Water Intake	□	□	_____

Female Related Questions

Age of first 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: OB/GYN exam: _____ PAP Smear: _____

Number of days of flow: _____ Mammogram: _____ Bone Density Scan: _____

Color of flow: _____ Results: _____

Clots? □ yes □ no Color: _____ _____

Average number of pads/tampons you use per day: 1st day ___ 2nd day ___ 3rd day ___4th day ___ + Days _____

Have you been diagnosed with:
□ Fibroids □ Fibrocystic breasts □ Endometriosis □ Ovarian Cysts □ PID □ Other

Location of pain:
□ Lower abdomen □ Lower back □ Thighs □ Other

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

Cramping: _____ Stabbing: _____ Burning: _____

Aching: _____ Dull: _____ Bloating: _____

Consistent: _____ Intermittent: _____ Bearing Down Sensation: _____

Other Symptoms related to menses:

□ Discharge	□ Vaginal Dryness	□ Headache	□ Nausea	□ Constipation
□ Diarrhea	□ Swollen breasts	□ Mood Swings	□ Ravenous Appetite	□ Poor Appetite
□ Hot Flashes	□ Night Sweats	□ Increased Libido	□ Decreased Libido	□ Insomnia

Male Related Questions

Date of last prostate check up: _____ PSA Results: _____ Manual Prostate exam results: _____

Lab Results: _____

Frequency of urination: daytime _____ nighttime ___ _____ Color of urine: □ clear □ murky Odor: _____

Symptoms related to prostate:

□ Prostate problems	□ Delayed Stream	□ Dribbling	□ Incontinence	□ Retention of Urine
□ Rectal Dysfunction	□ Increased Libido	□ Decreased Libido	□ Premature Ejaculation	□ Impotence
□ Back Pain	□ Groin Pain	□ Testicular Pain	□ Other _____	

General Questions

The following is a list of symptoms that you may or may not ever experience. Please indicate as follows:
No mark = Never experience | One checkmark = sometimes experience | Two checkmarks = Frequently experience

__ lack of appetite
__ feeling of claustrophobia
__ poor digestion/indigestion/vomiting
__ constipation
__ skin problems
__ feeling food retention in the stomach
__ eye problems
__ heart palpitations
__ gall stones
__ mentally restless
__ abdominal pain
__ headaches
__ shortness of breath
__ skin problems
__ easily angered or agitated
__ low back pain
__ ears ringing
__ hair loss
__ edema
__ easily bruised
__ tendency to catch colds easily
__ hay fever
__ high cholesterol levels
__ skin problems
__ loose stool or diarrhea
__ colitis or diverticulitis
__ heartburn/reflux
__ excessive appetite
__ recent use of antibiotics
__ insomnia, difficulty sleeping
__ difficulty digesting oily foods
__ nightmares
__ laughing for no apparent reason
__ chest pain
__ pain or coldness in the genital area
__ decreased sense of smell
__ bronchitis
__ difficulty in making plans/decisions
__ knee problems
__ kidney stones
__ urinary problems
__ blood in stool
__ difficulty in stopping bleeding
__ intolerance to weather changes
__ dizziness
__ sudden weight loss
__ excessive appetite
__ bronchitis
__ belching, burping
__ hemorrhoids
__ feeling of claustrophobia
__ tendency to become obsessive
__ jaundice (yellowish eyes or skin)
__ cold hands and feet
__ light colored stool
__ angina pains
__ sciatic pain
__ cough
__ nasal problems
__ soft or brittle nails
__ spasms or twitching of muscles
__ hearing impairment
__ decreased sex drive
__ fatigue
__ black tarry stool
__ asthma
__ allergies
__ tendency to faint easily

Additional Questions

How do you FEEL about the following areas of your life?
Please check the appropriate boxes and indicate any problems you may be experiencing.

	Great	Good	Fair	Poor	Bad	Your Comments
Significant Other	□	□	□	□	□	_____
Family	□	□	□	□	□	_____
Diet	□	□	□	□	□	_____
Sex	□	□	□	□	□	_____
Self	□	□	□	□	□	_____
Work	□	□	□	□	□	_____
Exercise	□	□	□	□	□	_____
Spirituality	□	□	□	□	□	_____

What are the main 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? _____

List any other health problems you now have. _____

_____

List any allergies, food sensitivities or food cravings that you have. _____

_____

Please list any accidents, surgeries, hospitalizations or other major health incidents in your life, including dates: ___

_____

Lab Results: (please include copies) _____

_____

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.