1000 Folded Cranes
Acupuncture

COMPREHENSIVE NEW PATIENT QUESTIONNAIRE

NOTE: This is a confidential record of your medical history and will be kept in this office.
Information contained herein will not be released pursuant to HIPAA regulations.

Name _____ Date _____
Primary Complaint?_____

_____

How long have you had this condition? _____ Have you had this before? _____
How does this problem interfere with your daily activities? _____

_____

What makes it better? _____ What makes it worse? _____
Is your condition: ☐Constant ☐Intermittent ☐Worse Pain Level: ☐Low ☐Slight ☐Moderate ☐Severe
Secondary Complaints? _____

_____Other

concurrent therapies_____
How are you responding to your present course of treatment? Better _____Worse _____ Same _____

Surgeries/Hospitalization *(please list dates also)*

_____

_____

_____

Significant Trauma/Accidents _____

Do you have? ☐Pacemaker ☐Metal Implants ☐Pregnant ☐Bleeding Disorder
Allergies? _____

Medications – prescription drugs, vitamins, supplements, herbs, etc. *(Use back if you need more room)*
Name_____ Dosage _____ To treat? _____
Name_____ Dosage _____ To treat? _____
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Stress ☐None ☐Low ☐Moderate ☐Severe Explain Causes:

_____

Energy Level ☐High ☐Low ☐Sudden Energy Drop (time of day?) _____
Exercise (type/frequency) _____

Habits: ☐Cigarettes ☐Coffee ☐Tea ☐Sodas ☐Alcohol Drugs _____

How much & how often? _____

Do you? ☐skip meals ☐snack ☐eat large meals ☐eat when rushed ☐work and eat ☐eat but not hungry

***YOUR* MEDICAL HISTORY**

☐Cancer ☐HIV+ ☐Diabetes ☐Heart Disease ☐High Blood Pressure ☐Low Blood Pressure ☐Stroke
☐Epilepsy ☐High Cholesterol ☐Asthma ☐Kidney Disease ☐Anemia ☐STD ☐Hepatitis ☐Jaundice
☐Thyroid Disease ☐Chronic Fatigue ☐Sudden Weight Loss ☐Sudden Weight Gain ☐Ulcers ☐Gallstones

Dates of Illness _____

***FAMILY* MEDICAL HISTORY**

☐Cancer ☐Diabetes ☐Kidney Disease ☐Heart Disease ☐High Blood Pressure ☐Stroke ☐Epilepsy
☐Low Blood Pressure ☐Asthma ☐Anemia ☐Bleeding Disorder ☐Hepatitis ☐ HIV+ ☐Thyroid Disease

Which family member? _____

For the following Sections on Organ Systems evaluation,
*please check any problems that are **frequent**, or that have **occurred recently***

MUSCULOSKELETAL PAIN

☐Neck ☐Back ☐Knee ☐Shoulder ☐Wrist ☐Hand ☐Ankle ☐Foot ☐Hip ☐Fingers ☐Toes

Other area _____ ☐Bones sore/painful ☐Loss of Grip ☐Swollen Joints ☐Weakness
☐Leg cramps at night ☐Tingling in feet ☐Tingling in hands ☐Loss of feeling in hands/feet
☐Muscle spasm/cramps ☐Stiffness all over ☐Osteo Arthritis ☐Rheumatoid Arthritis ☐Tendinitis ☐Sciatica

Onset of Pain: _____ Better with? _____ Worse with? _____

Describe the pain (burning/constant/intermittent/pins&needles/numbness/coldness/sharp/dull)

_____

HEAD, EYES, EARS, NOSE AND THROAT

☐Dizziness ☐Concussion ☐Poor Memory ☐Loss of Balance ☐Head feels 'Heavy' ☐Migraines
☐Headaches (describe) _____
☐Eye Strain ☐Eye Pain ☐Floaters ☐Blurred Vision ☐Dry Eyes ☐Watery Eyes ☐Itchy Eyes
☐Ear Ache ☐ Ear Infections ☐Hearing Loss ☐Ringing/Buzzing in Ears ☐Grinding Teeth ☐TMJ
☐Teeth Problems ☐Facial Pain ☐Facial Paralysis ☐Sensation of 'Lump' in Throat
☐Sinus Problems ☐Mucus ☐Nose Bleeds ☐Runny Nose ☐Congestion ☐Frequent Colds
☐Sore Throat ☐Copious Saliva ☐Dry Mouth ☐Difficulty Swallowing ☐Hoarseness/Loss of Voice

LUNG SYSTEM

☐Shortness of Breath ☐Difficulty Breathing ☐Wheezing ☐Cough ☐Asthma ☐Bronchitis
☐Pneumonia ☐Difficulty Breathing When Lying Down ☐Coughing Blood ☐Coughing Phlegm

Sputum color? _____ Thick or Thin? _____ Other?_____

HEART SYSTEM

☐Heavy Sleep ☐Insomnia ☐Wake Easily/ frequently ☐Wakes early (Time?) _____ ☐Restless
☐Difficulty falling asleep ☐Excess dreaming ☐Nightmares ☐Night sweating ☐Rarely sweat ☐Excess sweat
☐Snoring ☐Sleep Apnea ☐Fainting ☐Vertigo ☐Dizziness ☐Tremors ☐Fatigue ☐Cold Feet ☐Cold Hands
☐Swollen Hands/Feet ☐Tingling Hands/Feet ☐Localized Weakness ☐Fevers ☐Chills ☐Pain in Chest
☐High Blood Pressure ☐Low Blood Pressure ☐Pressure in Chest ☐Irregular Heart Beat ☐Palpitations

SKIN/HAIR

Frequent Rashes Eczema Hives Itching Purpura Dryness Clammy/Moist Burning
Changes in Moles or Lumps Bleeds/Bruises Easily Varicose/Spider Veins Hair Loss Dry Scalp
Change in Hair Texture Scars Other_____

DIGESTIVE SYSTEM

Poor Appetite Excess Hunger Feel tired if miss meal Cold Abdomen Weight Gain Weight Loss
Strong Thirst For cold? For hot? Never thirsty Crave Sweets Crave Salty Crave Sour
Specific food craving? _____ Peculiar Tastes or Smells? _____
Heartburn Nausea Vomiting Belching Abdominal Bloating Foul Breath Stomach Pain Gas
Diarrhea Constipation Flatulence Hemorrhoids Black Stools Bloody Stools Mucous Stools
Pain/Cramps Sensitive Abdomen Foul Odor Colitis Irritable Bowel Bowel Gas
BOWEL MOVEMENT: Frequency(#/day) _____ Color_____ Quality (loose/firm)_____
Sudden Energy Drop At _____(time) Fatique Heavy Limbs Weak Limbs Restless Energetic

URINARY SYSTEM

Urine color: _____ Clear Cloudy Dark Amount? _____ Frequent Urine?_____ Day Night
Pain/burning with Urination Pain before Urination Urgency to Urinate Incontinence Blood in Urine
Kidney Stones Frequent Infections Strong urine smell Cold Back Other_____

For Men

Prostate Enlarged Elevated PSA Impotence Low Sex Drive Painful Ejaculation Premature Ejaculation
Discharges Other_____

REPRODUCTIVE SYSTEM (for Women only)

Pregnant? # of pregnancies____ # of Deliveries ____ # Miscarriages _____ # of Abortions _____
Age Started menstrual cycle_____ Age Stopped _____ Last Monthly Period _____
Period Duration _____ Birth Control Method_____ Last PAP? _____
Heavy Flow Light Flow Color (pale/dark/red/purple?) _____
Irregular Periods Scanty Periods Missed Periods Dysmenorrhea Clots Cramps Spotting
Vaginal Discharges: Yellow White Thick Thin Itching Odor
Breast Lumps Breast Pain Menopause PMS Fibroids Endometriosis Low Libido
Low Backache Water Retention Hot Flashes Other_____

EMOTIONAL & NEUROLOGICAL

Seizures Tremors Numbness/Tingling Always Cold Always Hot Poor Coordination
Neuralgia (pain) Shingles Other _____
Nervousness Depressed Anxiety/Worry Easily Angered Easily Irritated Stressed
Giddy Sadness/Grief Frequent Crying Mood Swings Suicidal Phobias/Fears Manic
Panic Attacks Indecisive Other Emotional _____

Thank you for completing this confidential, medical history questionnaire. Your honest, complete answers will assist me in providing you with the best possible health care.