

Boca Acupuncture

Please fill out this CONFIDENTIAL questionnaire to help us determine the best treatment plan for you. Thank you.

Personal Information:

Today's Date: _____

Name: _____ Age: _____ Birth Date: _____

Address: _____

City: _____ State: _____ Zip: _____

Primary Phone number: _____ Add'l phone number _____

E-mail address: _____

If under 18, person responsible for your account: _____

Emergency Contact: Name: _____ Relationship: _____ Contact Phone: _____

Whom shall I thank for referring you to Boca Acupuncture? _____

Have you had acupuncture therapy before? Yes No

Please indicate if any of the following pertain to you:

- Hepatitis HIV High Blood Pressure Seizures Pacemaker
- Blood-Thinning Medication Pregnancy

Please indicate how frequently you consume the following:

Coffee: _____ Soda: _____ Water: _____

Alcohol: _____ Tobacco: _____

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

Medication / Supplement	Reason	For how long now?
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Health History

Please indicate your top 3 health concerns for which you are seeking treatment and how long you have been experiencing them:

1. _____
2. _____
3. _____

What other forms of treatment have you sought?

What helps your condition?

What aggravates your condition?

What would you like to achieve with our intuitive acupuncture sessions?

As we will discuss, your health transformation is a process.

Please include your short-term health goals:

Please include your long-term health goals:

Please indicate your level of commitment to these goals. (How frequently will you be coming in? Will you carry out suggestions, including dietary modifications, that you may be recommended?)

Please list any surgeries or major health incidents (accidents, etc.) in your life and the date of occurrence:

If you experience any physical pain, please indication where and since when:

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How would you characterize your physical pain?

- dull/achy sharp/stabbing burning tingling /numbness electrical
 continuous comes and goes fixed location moves around shooting/ radiating

Symptoms Survey

Please indicate the symptoms or conditions you currently experience or have experienced them in the past:

Earth	Currently	Past	Wood	Currently	Past
Excessive appetite	<input type="checkbox"/>	<input type="checkbox"/>	Eye Problems	<input type="checkbox"/>	<input type="checkbox"/>
Loose stools / diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	Jaundice	<input type="checkbox"/>	<input type="checkbox"/>
Digestive problems <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty ingesting	<input type="checkbox"/>	<input type="checkbox"/>
Gas or bloating	<input type="checkbox"/>	<input type="checkbox"/>	Belching	<input type="checkbox"/>	<input type="checkbox"/>
Obsession	<input type="checkbox"/>	<input type="checkbox"/>	Acid Reflux /heart burn	<input type="checkbox"/>	<input type="checkbox"/>
Worry thoughts	<input type="checkbox"/>	<input type="checkbox"/>	Easily Frustrated/angered	<input type="checkbox"/>	<input type="checkbox"/>
Lack of appetite	<input type="checkbox"/>	<input type="checkbox"/>	Depression	<input type="checkbox"/>	<input type="checkbox"/>
Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty making decisions	<input type="checkbox"/>	<input type="checkbox"/>
Low energy after a meal	<input type="checkbox"/>	<input type="checkbox"/>	Gallstones	<input type="checkbox"/>	<input type="checkbox"/>
Sweet cravings	<input type="checkbox"/>	<input type="checkbox"/>	Ringing in the ears	<input type="checkbox"/>	<input type="checkbox"/>
Hemorrhoids	<input type="checkbox"/>	<input type="checkbox"/>	Brittle hair or nails	<input type="checkbox"/>	<input type="checkbox"/>
Low blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	High cholesterol	<input type="checkbox"/>	<input type="checkbox"/>
Fire	Currently	Past	Metal	Currently	Past
Insomnia	<input type="checkbox"/>	<input type="checkbox"/>	Cough	<input type="checkbox"/>	<input type="checkbox"/>
Heart palpitations	<input type="checkbox"/>	<input type="checkbox"/>	Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>
Nightmares	<input type="checkbox"/>	<input type="checkbox"/>	Decreased sense of smell	<input type="checkbox"/>	<input type="checkbox"/>
Mentally restless	<input type="checkbox"/>	<input type="checkbox"/>	Colitis/diverticulitis	<input type="checkbox"/>	<input type="checkbox"/>
Chest pain	<input type="checkbox"/>	<input type="checkbox"/>	Tightness in the chest	<input type="checkbox"/>	<input type="checkbox"/>
Poor memory	<input type="checkbox"/>	<input type="checkbox"/>	Constipation	<input type="checkbox"/>	<input type="checkbox"/>
Sadness/loneliness	<input type="checkbox"/>	<input type="checkbox"/>	Grief/ Nostalgia	<input type="checkbox"/>	<input type="checkbox"/>
Agitation/Fidgeting	<input type="checkbox"/>	<input type="checkbox"/>	Claustrophobia	<input type="checkbox"/>	<input type="checkbox"/>

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	Currently	Past	Blood & Dampness	Currently	Past
Water					
Lower back pain	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Knee pain/ problems	<input type="checkbox"/>	<input type="checkbox"/>	Sluggishness/Grogginess	<input type="checkbox"/>	<input type="checkbox"/>
Hearing impairment	<input type="checkbox"/>	<input type="checkbox"/>	Nausea	<input type="checkbox"/>	<input type="checkbox"/>
High or low libido	<input type="checkbox"/>	<input type="checkbox"/>	Heavy feeling	<input type="checkbox"/>	<input type="checkbox"/>
Hair loss	<input type="checkbox"/>	<input type="checkbox"/>	Dark circles under eyes	<input type="checkbox"/>	<input type="checkbox"/>
Urinary problems	<input type="checkbox"/>	<input type="checkbox"/>	Blood clotting disorder	<input type="checkbox"/>	<input type="checkbox"/>

I usually feel : Hot Cold I'm often thirsty Dry mouth/throat

For Women

Age of first period: _____ Date of last period: _____ Number of days between periods: _____
 Number of pregnancies: _____ Miscarriages: _____ Abortions: _____
 Are you currently sexually active? Yes No Partners are: Men Women

Number of days of flow: _____

Please indicate color of blood and number of pads/tampons per day of flow below:

Color: *Pale/light red * Bright red * Dark red/brown | Cramping: * Mild *Moderate *Severe | # of pads: *1-3 *4-7 *8+

Day 1,2	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Day 3,4	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Day 5+	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please indicate if you experience the any of these symptoms during your menses:

- | | | | | |
|--|---|---|---|---|
| <input type="checkbox"/> Lower back pain | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Constipation | <input type="checkbox"/> Moodiness/Weepy | <input type="checkbox"/> Breast pain/soreness |
| <input type="checkbox"/> Blood clots | <input type="checkbox"/> Increased appetite | <input type="checkbox"/> Decreased appetite | <input type="checkbox"/> Headache | |
| <input type="checkbox"/> Nausea | <input type="checkbox"/> Insomnia | <input type="checkbox"/> More tired | <input type="checkbox"/> Hemorrhoids | |
| <input type="checkbox"/> Bloating | <input type="checkbox"/> Down-bearing sensation | <input type="checkbox"/> Scant or late menses | <input type="checkbox"/> Irregular menses | |

Please indicate if you experience any of these other gynecological symptoms:

- Vaginal dryness Profuse vaginal discharge Yeast infections Urinary tract infections

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Please indicate if you have been diagnosed with any of the following:

- Fibroids
- Fibrocystic breasts
- Endometriosis
- Ovarian Cysts
- Polycystic Ovary Syndrome
- Pelvic Inflammatory Disorder

Please list any STDs you have: _____

For Men

Date of your last prostate exam: _____ Are you currently sexually active? Yes No

Partners are: Male Female Please list any STDs you have: _____

Please explain any concerns you may have with your sexual function or libido:

Lifestyle

How many hours of sleep do you get each night? _____

Do you experience: Difficulty falling asleep Staying asleep Interrupted sleep

Nightmares Vivid dreams Wake up not well-rested/groggy

How many bowel movements do you have in a day or week? _____

Are your bowel movements: Well-formed Loose Small pebbles Tan Almost black
 Easy to pass Difficult to pass Sticky, like you have to wipe a lot

How would you rate your energy level on a scale of 1-10, with 10 being the highest: _____

How would you rate your stress level on a scale of 1-10, with 10 being the highest: _____

Please list your primary sources of stress: _____

How much do you think about them? How much do they impact your life?

How many hours do you work per week? _____ Do you like your work? _____

What do you do in order to manage your stress and take care of yourself?

Did I miss anything? Anything else you'd like me to know?

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