



570 South Broadway Denver, Co 80209
303-777-0320

This is a CONFIDENTIAL questionnaire to help us determine the best treatment plan for you. If you have questions, please ask! Thank you.

Personal Information

Name _____ Date _____

Home Address _____

City _____ State _____ Zip _____

Cell Phone _____ Email _____

Occupation _____ Work Phone _____

Emergency Contact: Name _____ Phone _____

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

Sex: _____ Height _____ Weight _____ Ideal Weight _____ Birthdate _____ Age _____

Marital Status: Single Married Divorced Widowed Partnered Number of children _____

Have you received acupuncture therapy before? _____

When? _____ With whom? _____

Do you have a fear of needles? _____

Please indicate any significant illnesses you or a blood relative (grandparent, parent or sibling) have had:

Illness	You	Your Relative	Approx. Date	Illness	You	Your Relative	Approx. Date
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	_____	Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	_____	Seizures	<input type="checkbox"/>	<input type="checkbox"/>	_____
Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	_____	Emotional Disorders	<input type="checkbox"/>	<input type="checkbox"/>	_____
Infectious Diseases	<input type="checkbox"/>	<input type="checkbox"/>	_____	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	_____

Sexually Transmitted Diseases: Gonorrhea Syphilis AIDS HPV Chlamydia Herpes Date _____

List all medications or supplements you are currently taking (Continue on back if necessary).

Medication	Dosage	Reason	How long	Date of last checkup
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Please indicate the use and frequency of the following:

	Yes	No	Amount	Yes	No	Amount	Yes	No	Amount		
Coffee	<input type="checkbox"/>	<input type="checkbox"/>	_____	Tobacco	<input type="checkbox"/>	<input type="checkbox"/>	_____	Water Intake	<input type="checkbox"/>	<input type="checkbox"/>	_____
Recreational drugs	<input type="checkbox"/>	<input type="checkbox"/>	_____	Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	_____	Soda Pop	<input type="checkbox"/>	<input type="checkbox"/>	_____



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What is your main reason for seeking treatment? _____

What other treatment have you sought? _____

List any other health problems you have. _____

List any allergies, food sensitivities or cravings. _____

List any accidents, surgeries, or hospitalizations (include dates). _____

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	Comments
Significant-						
Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Family	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Sex	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Self	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Work	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Exercise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Spirituality	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

Women:

Are you pregnant? Yes No # of pregnancies ____ # of live births ____ #abortions ____ # miscarriages ____

Number of days between periods _____ Number of days of flow _____ Color of flow _____

Do you have clots? _____ Size _____

PMS symptoms (if yes, please list) _____

Average number of pads/tampons you use per day: Day 1 ____ Day 2 ____ Day 3 ____ Day 4 ____ Day 5 ____

Have you been diagnosed with: Fibroids Fibrocystic Breasts Endometriosis Ovarian Cysts PID Other _____



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Symptom Survey (for everyone)

The following is a list of symptoms that you may or may not ever experience. Please indicate as follows:

No mark = never experience check mark (✓) = sometimes experience plus sign (+) = frequently experience

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