



Golden Valley Acupuncture Center
dedicated to wellness

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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	<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 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
<hr/>					
<hr/>					
<hr/>					

Please indicate the use and frequency of the following:

	Yes	No	How Much		Yes	No	How Much
Coffee/Black Tea	<input type="checkbox"/>	<input type="checkbox"/>	_____	Tobacco	<input type="checkbox"/>	<input type="checkbox"/>	_____
Soda Pop	<input type="checkbox"/>	<input type="checkbox"/>	_____	Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	_____
Recreational Drugs	<input type="checkbox"/>	<input type="checkbox"/>	_____	Water Intake	<input type="checkbox"/>	<input type="checkbox"/>	_____

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

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

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	<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"/>	_____

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.