New Leaf Acupuncture Clinic - New Patient Questionnaire

Name _____Gender_____ Today's Date _____ Birth date _____

Address_____

E-mail address _____Phone:_____

Marital Status _____ No. of Children _____ Occupation_____

Emergency Contact: Name _____Phone ___

Primary Care Practitioner:_____

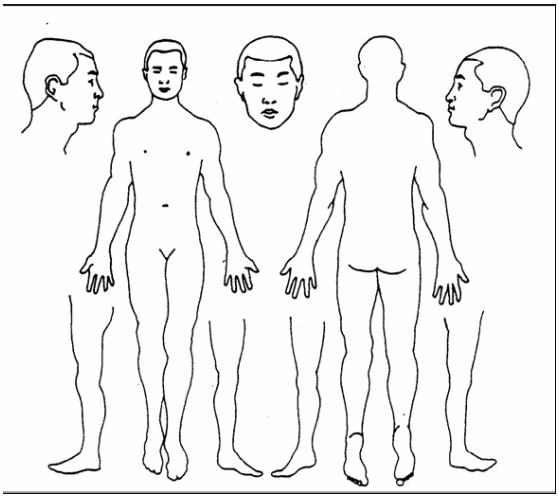
Is this your first time getting acupuncture? **Y** / **N** How did you hear about us?_____

Goals: What would you most like to achieve with acupuncture treatments?

_____
_____
_____

Major Symptoms: Please list in order of importance what symptoms are of concern to you.
(most concerning to least, along with the duration of the symptom)

_____
_____
_____



Experiencing pain/discomfort in any area of your body? **Y / N**

Please rate your pain level.
1 2 3 4 5 6 7 8 9 10

Duration of pain: _____

Use the illustration to indicate painful or distressed areas. Indicate the location of the discomfort by using the symbol that best describes the feeling:

X X X *Sharp/Stabbing* P P P *Pins & Needles*

D D D *Dull/Aching* N N N *Numbness*

T T T *Tightness/Spasms*

Aggravating factors: (i.e. Heat) _____Alleviating factors: (i.e. Cold) _____

Medical History
Do you or have you had any of the following conditions? If yes, please indicate date of diagnosis.

Date Diagnosed Date Diagnosed

Cancer (type):_____ Hepatitis _____

HIV _____ Stroke _____

Diabetes _____ High Blood Pressure _____

Mental Illness _____ Thyroid Disease _____

Heart Disease _____ High Cholesterol _____

Seizures _____ Other _____

Please list any surgeries or major injuries with dates.

_____
_____
_____

List any medications or supplements you have taken in the last 2 months.

_____
_____
_____

Do you have a pacemaker or any metal devices in your body? *Y / N*

Family History
Indicate close family members with any of the following:

Family member(s) Family Member(s)

Cancer (specify type) _____ Heart Disease _____

High Cholesterol _____ Stroke _____

Diabetes _____ High Blood Pressure _____

Mental Illness _____ Alcoholism _____

Lifestyle Habits

Do you have an exercise routine? *Y / N* Please describe.

_____
_____
_____

How many hours per night do you sleep on average? _____ Do you wake rested? *Y / N*

Nicotine Use: _____ Alcohol Use (#drinks/week and type):_____

Caffeine Use (#drinks/day and type): _____Water intake (how much/day): _____

Briefly describe your dietary habits (#meals/day and type of food)

_____
_____
_____
_____

Energy:
How is your energy? Please circle. Low 1 2 3 4 5 6 7 8 9 10 high

What time of day is your energy:

Highest: *6am-12pm* *1pm-5pm* *6pm-12am*

Lowest: *6am-12pm* *1pm-5pm* *6pm-12am*

Do you fatigue easily? *Yes/ No*

How do you feel emotionally?

_____
_____
_____
_____

Do you have (circle all that apply): *Panic attacks / Depression / Anxiety / Bad temper*

Nervousness / Fear attacks / Poor memory / Difficult concentration

Bowel movements: How often? _____time(s)/day or _____days/week

I have or had (circle all that apply): *Irregular Bowel Movements / Constipation / Diarrhea / Undigested food in stools / Burning sensation / Hemorrhoids / Itchiness / Painful bowel movements / Loose stool / Hard stool / Blood in stool / Gas / None of the above*

Urination: How often?_____times per day

Color (please circle): *Pale yellow / Dark yellow/orange*

I have or had (circle all that apply): *Trouble starting stream Frequent urination / Incontinence Dribbling when sneezing / Burning Pain / Other_____ / None of the above*

Women Only: Are you pregnant: Y / N Number of pregnancy's _____

Age of first menses: _____ Number of days between cycles:_____

Number of flow days:_____ Typical Color (please circle):: *dark red / bright red / pale red*

I have or had (check all that apply): *Irritability / Breast Tenderness / Cravings / Cramps*

Vaginal discharge? *No / Yes* Color_____

Please check all that apply

Energy and Immunity
__ Fatigue
__ Allergies (which?)_____
__ Anemia
__ Chronic Fatigue Syndrome
__ Thyroid Problems
__ Tendency to Catch Colds

Head, Eye, Ear, Nose, and Throat
__ Eye Dryness
__ Blurry Vision
__ Poor Night Vision
__ Ear Ringing
__ Hearing Difficulties
__ Headaches / Migraines
__ Teeth Grinding / TMJ
__ Sore Throat
__ Chronic Sinus Congestion
__ Dry Mouth
__ Bad Breath
__ Mouth Sores / Bleeding Gums
__ Increase in Thirst

Emotions / Sleep
__ Mood Swings
__ Anxious / Worried
__ Depressed
__ Irritable
__ Difficulty Making Decisions
__ Stressed
__ Insomnia
__ Nightmares
__ Difficulty Falling or Staying Asleep

Respiratory/Cardiovascular
__ Shortness of Breath
__ Asthma
__ Chest Pain
__ Palpitations / Fluttering
__ Poor Circulation (Cold hands/feet)
__ Chronic Cough
__ Night Sweats
__ Unusual Sweating
__ Hot/Cold Intolerance

Gastrointestinal
__ Ulcers
__ Changes in Appetite
__ Nausea / Vomiting
__ Bloating / Pain
__ Gas
__ Heartburn / Acid Reflux
__ Belching
__ Hemorrhoids
__ Diarrhea
__ Constipation
__ Sudden Weight Change

Kidney/Urinary
__ Painful Urination
__ Frequent Urinary Tract Infections
__ Frequent / Urgent Urination
__ Edema / Swelling

Musculoskeletal
__ Neck / Shoulder Pain
__ Muscle: Spasms/Cramps/Weakness
__ Arm Pain
__ Finger Pain / Tingling / Numbness
__ Upper Back Pain
__ Mid Back Pain
__ Low Back Pain
__ Leg / Knee Pain
__ Foot / Ankle Pain
__ Hip / Pelvic Pain
__ Arthritis

Neurological
__ Vertigo / Dizziness
__ Numbness / Tingling
__ Poor Concentration or Memory

Skin
__Rashes / Eczema / Hives / Psoriasis
__ Dry Hair or Hair Loss
__ Changes in Skin Color
__ Easy Bruising
__ Acne
__ Dry / Itchy Skin

Female Health
__ Irregular Cycle
__ Heavy Flow
__ Light Flow
__ Clots in Menstrual Blood
__ Menstrual Related Moodiness
__ Menstrual Related Breast-Tenderness
__ Menstrual Related Bloating
__ Bleeding Between Cycles
__ Painful Periods
. . . (Is pain before, during and/or after period?) _____
__ Hot flashes
__ Vaginal Dryness
__ Breast Lumps / Cysts
__ Uterine Fibroids
__ Endometriosis
__ Ovarian Cysts
__ Unusual Vaginal Discharge Odor
__ Frequent Yeast Infections
__ Decreased Libido

Male Health
__ Prostate Enlargement
__ Impotence
__ Premature Ejaculation
__ Decreased Libido
__ Groin Pain

Acupuncture Appointments

Please bring your new patient questionnaire filled out with you to your first appointment.

Please bring or wear loose clothing (shorts, t-shirts) to each appointment.

Please eat a light meal or snack before your appointment; an empty stomach may cause dizziness.

Please DO NOT eat or drink food that may change the color of your tongue or brush your tongue the day of your appointment. (coffee, fizzy drinks, juice, liquorice, beetroot, etc)

While contra indications for acupuncture are rare and, although also rare, sometimes a small local bruise can occur.

Please verify with your insurance company to see if you have acupuncture benefits prior to your treatment.

What to expect at your first visit?

Your first visit will take a little over one hour and will include an acupuncture treatment. We will discuss your health questionnaire and any concerns you have prior to the treatment. I will make a diagnosis, a treatment plan and a few suggestions regarding your condition. If you have any questions please do not hesitate to email or call me at :

niall@newleafacupuncture.ie

(087) 2632732

Niall O'Leary
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Financial Policy

Payment is due at time of service for all patients. A fee will be charged for missed appointments or cancellations without a 24-hour notification.

_____ _____

Signature Date

_____

Please Print Name