New Leaf Acupuncture Clinic - New Patient Questionnaire

The following information is helpful to the diagnostic procedure and enables us to provide you with better treatment.

Name _____ ☐ *Female* ☐ *Male* Birth Date _____ Today's Date _____

Address _____

E-mail address _____ Phone _____

Marital Status _____ No. of Children _____ Occupation _____

Emergency Contact Name _____ Phone _____

Doctor _____

Is this your first time getting acupuncture? ☐*Yes* ☐ *No*. How did you hear about us? _____

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

_____

_____

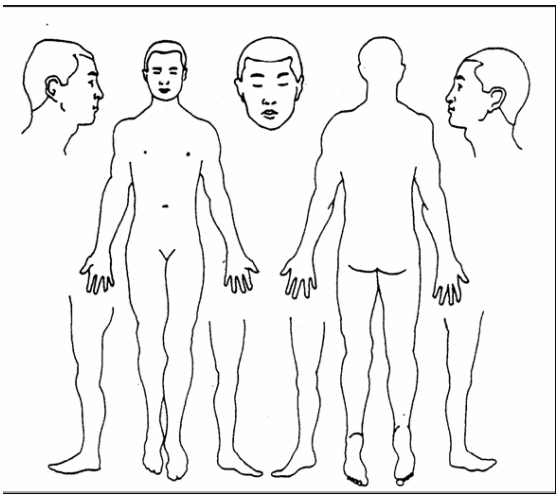
_____

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? ☐*Yes* ☐*No*

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: (eg. Heat) _____ Alleviating factors: (eg. 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? ☐ *Yes* ☐ *No.* If so, which: _____

Intolerant of, or allergic to: ☐ Alcohol Swabs ☐ Iodine ☐ Arnica Cream ☐ Bio Oil

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? ☐ *Yes* ☐ *No*
Please describe _____

_____

_____

How many hours per night do you sleep on average? _____ Do you wake rested? ☐ *Yes* ☐ *No*

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; type of food; snacks; sweet tooth)

_____

_____

_____

_____

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?

_____

_____

Emotions: How are your stress levels? Please circle. Low < 1 2 3 4 5 6 7 8 9 10 > High

Do you have: ☐ *Panic attacks* ☐ *Depression* ☐ *Anxiety/Worry* ☐ *Irritability* ☐ *Nervousness*

☐ *Fear attacks* ☐ *Mood Swings* ☐ *Difficulty Making Decisions* ☐ *Poor memory* ☐ *Difficult concentration*

☐ *Suppressing Emotions* ☐ *Frequent Sighing* ☐ *Easily Startled*

Bowel movements:
How often?___time(s) a day, or __ time(s) a week

I have or had:
☐ Irregular Bowel Movements
☐ Constipation
☐ Diarrhoea
☐ Painful bowel movements
☐ Undigested food in stools
☐ Burning sensation
☐ Haemorrhoids
☐ Itchiness
☐ Loose stools
☐ Hard stools
☐ Blood in stools
☐ Gas
☐ None of the above

Urination:
How often?_____times per day

Color:
☐ Pale yellow
☐ Dark yellow/orange

I have or had:
☐ Trouble starting stream
☐ Frequent urination
☐ Incontinence
☐ Dribbling when sneezing
☐ Burning Pain
☐ Other_____
☐ None of the above

Please tick symptoms you have or have had in the past year:

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

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

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

Sleep
☐ Insomnia
☐ Nightmares
☐ Difficulty Falling Asleep
☐ Difficulty Staying Asleep
☐ Waking Up Early
☐ Restless Sleep
☐ Excessive Dreaming

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

Gastrointestinal
☐ Ulcers
☐ Changes in Appetite
☐ Nausea / Vomiting
☐ Belching
☐ Bloating / Pain
☐ Gas
☐ Heartburn / Acid Reflux
☐ Belching
☐ Sudden Weight Change

Kidney/Urinary
☐ Painful Urination
☐ Frequent Urinary Tract Infections
☐ Frequent / Urgent Urination
☐ Oedema / Swelling

Respiratory/Cardiovascular
☐ Shortness of Breath
☐ Asthma
☐ Chest Pain
☐ Heart Palpitations / Fluttering
☐ Poor Circulation (Cold hands/feet)
☐ Chronic Cough
☐ Night Sweats
☐ Unusual Sweating
☐ Particularly sensitive to the cold
☐ Particularly sensitive to heat

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

Skin
☐ Rashes/Eczema/Hives/Psoriasis
☐ Dry Hair or Hair Loss
☐ Changes in Skin Color
☐ Easy Bruising
☐ Acne
☐ Dry / Itchy Skin
☐ Brittle Nails

Women Only:

Currently Pregnant? ☐*Yes* ☐*No*
Number of pregnancies: _____

Age of first menses: _____
Number of days in cycle: _____
Number of flow days: _____

Typical Color: ☐ dark red
☐ bright red
☐ pale red
☐ Mid-cycle mucus
☐ Irregular Cycle
☐ Heavy Flow
☐ Light Flow

☐ Vaginal discharge. Colour?_____
☐ Unusual Vaginal Discharge Odor

I have or had:
☐ Strong PMS symptoms
☐ Irritability
☐ Breast Tenderness
☐ Cravings
☐ Cramps
☐ Clots in Menstrual Blood
☐ Menstrual Related Moodiness
☐ " " Breast-Tenderness
☐ Menstrual Related Bloating

Female Health
☐ Vaginal Dryness
☐ Breast Lumps / Cysts
☐ Uterine Fibroids
☐ Endometriosis
☐ Ovarian Cysts
☐ Frequent Yeast Infections
☐ Hot flashes
☐ Decreased Libido
☐ Bleeding Between Cycles
☐ Painful Periods
. . . ☐ before ☐ during ☐ after

Acupuncture Appointments

Please bring this completed new patient questionnaire 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.

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 may give a few suggestions regarding your condition. If you have any questions please do not hesitate to email or call me at:

niall@newleaf.ie

(087) 2632732

Niall O'Leary

New Leaf Acupuncture Clinics:
212 Kimmage Road Lower, Dublin 6w
50 Marian Road, Rathfarnham, Dublin 14
15 Grantham St, Portobello, Dublin 8

Financial Policy, etc

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.

I also understand that these treatments may produce some bruising and I release the practitioner from liability in the event that that should occur.

_____ _____

Signature Date

_____

Please Print Name