

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 _____ Gender _____ Today's Date _____ Birth date _____

Address _____

E-mail address _____ Phone _____

Marital Status _____ No. of Children _____ Occupation _____

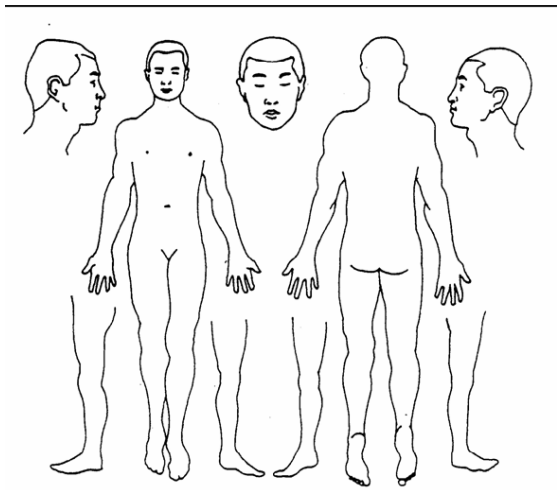
Emergency Contact: Name _____ Phone _____

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?

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 Bad temper Nervousness Fear attacks

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
- Diarrhea
- Painful bowel movements
- Undigested food in stools
- Burning sensation
- Hemorrhoids
- 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

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:

- Irritability
- Breast Tenderness
- Cravings
- Cramps
- Clots in Menstrual Blood
- Menstrual Related Moodiness
- " " " Breast-Tenderness
- Menstrual Related Bloating

Female Health

- 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
- Frequent Yeast Infections
- Decreased Libido

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

Skin

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

Emotions / Sleep

- Mood Swings
- Anxious / Worried
- Depressed
- Irritable
- Difficulty Making Decisions
- Stressed
- 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
- 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

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

Neurological

- Vertigo / Dizziness
- Numbness / Tingling
- Poor Concentration or Memory

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

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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