Midwest Acupuncture Group

Acupuncture ● Chinese Herbs ● Body Work

This is a confidential questionnaire to help us determine the best treatment plan for you. If you have any questions regarding this form, please don't hesitate to ask.

Name ____ Date ____________________

Home Address ____

City _________________________________ State ____________ Zip ___________________

Best Contact # ____

E-mail (for appointment confirmation) ____

Occupation ____

How did you hear about us? ____

Sex: Male ( ) Female ( ) Height _____________ Birth Date ____________ Age ________

Marital Status: Married ( ) Single ( ) Divorced ( ) Widowed ( ) Partnership ( )

Number of Children _________

Have you received acupuncture therapy before? Yes ( ) No ( )

If yes, when? ___________________________ With Whom? ____________________________

What are the main issues for which you are seeking treatment today?

1) ____
2) ____
3) ____

Please list any medications and/or supplements you are currently taking.

Medication Reason How long?

____

____

____

Please indicate the use and frequency of the following:

	Yes	No	How much? How often?
Coffee/Tea	____	____	________________________________
Recreational drugs	____	____	________________________________
Tobacco	____	____	________________________________
Alcohol	____	____	________________________________
Water	____	____	________________________________
Soda	____	____	________________________________

List any allergies, food sensitivities or cravings that you have: ______________________________

____

____

List any accidents, surgeries, or hospitalizations (include year). ____________________________

____

____

How do you feel about the following areas of your life?

	Great	Good	Fair	Poor	Bad
Significant other	( )	( )	( )	( )	( )
Family	( )	( )	( )	( )	( )
Diet	( )	( )	( )	( )	( )
Sex	( )	( )	( )	( )	( )
Self	( )	( )	( )	( )	( )
Work	( )	( )	( )	( )	( )
Exercise	( )	( )	( )	( )	( )
Spirituality	( )	( )	( )	( )	( )

Comments on the above: ____

____

____

Is there anything else you think is important for your Chinese Medical Practitioner to know?

____

____

____

For Women

Age of menarche (1st period) ____________ Age of last period (menopause) ______________

Number of days in cycle ________________ Number of days of flow ____________________

Color of flow __________________________ Clots? Yes ( ) No ( )

Have you been diagnosed with any of the following conditions?

Fibroids _______ Fibrocystic Breasts ________ Endometriosis _________

Ovarian cysts _____ Pelvic Inflammatory Disease (PID) _________ HPV _________

Are any of the following associated with your menstrual cycle?

Cramping __________ Stabbing pain ________ Bloating ___________

Headaches __________ Mood changes _________ Breast tenderness _________

Discharge __________ Nausea ________ Poor appetite ________

Increased appetite ________ Hot flashes __________ Insomnia _____________

Are you pregnant? Yes ( ) No ( )

# of pregnancies ________ # of live births ________ # of miscarriages ________

# of abortions _________ # of IVF/IUF treatments __________

Date of last gynecologic exam ______________ Pap smear _______________

Mammogram _______________ Results ____

____

For Men

Date of last prostate exam _______________ PSA results _________________

Other lab results ____

Do you have any of the following?

Prostate problems ( ) Delayed stream ( ) Dribbling urine ( )
Premature ejaculation ( ) Testicular pain ( ) Incontinence ( )
Increased libido ( ) Decreased libido ( ) Groin pain ( )
Impotence ( ) Other ( ) Explain: ____________________________

For Women and Men

Frequency of urination _______ a day

Do you wake up at night to urinate? Yes ( ) No ( ) How many times? _________

Have you experienced any of the following signs / symptoms?

No mark ( ) = never experience
Check mark (√) = sometimes experience
Plus sign (+) = frequently experience

___excessive appetite	___insomnia	___cough
___lack of appetite	___palpitations	___shortness of breath
___ loose stool/diarrhea	___cold hands/feet	___decreased sense of smell
___digestive problems	___nightmares/vivid dreams	___nasal problems
___vomiting/nauseated	___mental restlessness	___skin problems
___belching/burping	___laughing for no reason	___claustrophobia
___heartburn/reflux	___chest pains	___colitis/diverticulitis
___bloating	___poor memory	___ constipation
___obsession in work, relationships, etc..	___sadness/depression	___blood in stool/hemorrhoids

___low back pain	___eye problems	___fatigue
___knee problems/pain	___jaundice	___edema
___hearing impairment	___difficulty digesting greasy foods	___asthma
___ear ringing	___gallstones	___dizziness
___kidney stones	___soft/brittle nails	___easily/frequently gets sick
___decreased sex drive	___easily angered	___headaches
___hair loss	___bitter taste in mouth	___usually feels warm
___urinary problems	___difficult making decisions	___usually feel cold
___easily bruised	___high cholesterol	___depression
___ dental problems	___light colored stool	___anxiety

Signature ____

Date ________________________

Cancellation Policy: Appointments must be cancelled or changed within 24 hours of scheduled time. Without this appropriate notice, an $80 fee will be incurred. If less than 24 hour notice is given, **but you reschedule for the same week as your original appointment**, the fee will be waived.

I understand the above cancellation policy (please initial) ______________________________

Notes: