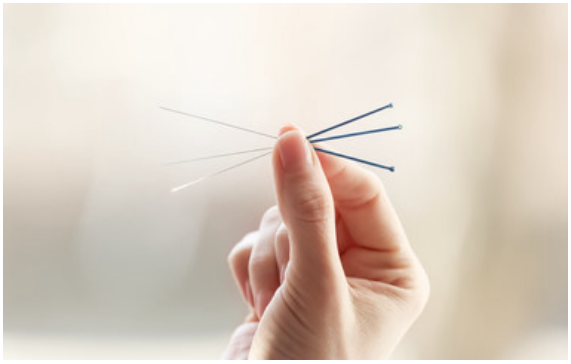


New Patient Questionnaire

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 _____

Huisarts _____

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?

_____

_____

_____

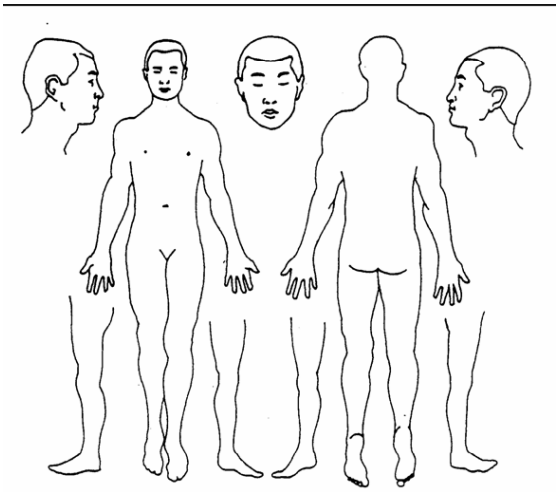
Major Symptoms: Please, list in order of importance what symptoms are of concern to you.

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

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

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)
_____

High Cholesterol
_____

Diabetes
_____

Mental Illness
_____

Heart Disease _____

Stroke _____

High Blood Pressure _____

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:

Color:
☐ Pale yellow
☐ Dark yellow/orange

I have or had:
☐ Trouble starting stream
☐ Frequent urination
☐ Incontinence
☐ Dribbling when sneezng
☐ 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 Odour

I have or had:

- ☐ Strong PMS symptoms
- ☐ Irritability
- ☐ Breast Tenderness
- ☐ Cravings
- ☐ Cramps
- ☐ Clots in Menstrual Blood
- ☐ 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 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 on: healingneedleacupunctuur@gmail.com

06-82869568

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

_____

Name