



128 S. Eagle Road, Eagle, ID 83616 (208)-938-1277 [www.EagleAcupuncture.com](http://www.EagleAcupuncture.com)

This is a CONFIDENTIAL questionnaire to help us determine the best treatment plan for you. Please fill it out as completely as possible even if you do not feel certain questions pertain to your present condition. Thank you.

### Personal Information

Name \_\_\_\_\_ Age \_\_\_\_\_ Birth Date \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Mobile \_\_\_\_\_

E-mail \_\_\_\_\_

Emergency Contact: Name \_\_\_\_\_ Contact Phone: \_\_\_\_\_

Whom should we thank for referring you to our office? \_\_\_\_\_

Have you had acupuncture therapy before?  Yes  No With Whom? \_\_\_\_\_

**Please indicate if any of the following pertain to you: (marking “yes” does not make you ineligible for treatment, however, it may restrict some of our treatment modalities):**

Hepatitis  HIV  High Blood Pressure  Seizures  Pacemaker  Blood-Thinning Meds  Pregnancy

**Please indicate the use and frequency of the following:**

Coffee \_\_\_\_\_ Soda pop \_\_\_\_\_ Water \_\_\_\_\_

Alcohol \_\_\_\_\_ Recreational drugs \_\_\_\_\_ Tobacco \_\_\_\_\_

**Please list any prescription or over-the-counter medications and supplements you are presently taking:**

Medications and Supplements	Reason
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

## Health History

What are the health problems for which you are seeking treatment? \_\_\_\_\_

\_\_\_\_\_

How long have you had this condition? \_\_\_\_\_

What other forms of treatment have you sought? \_\_\_\_\_

\_\_\_\_\_

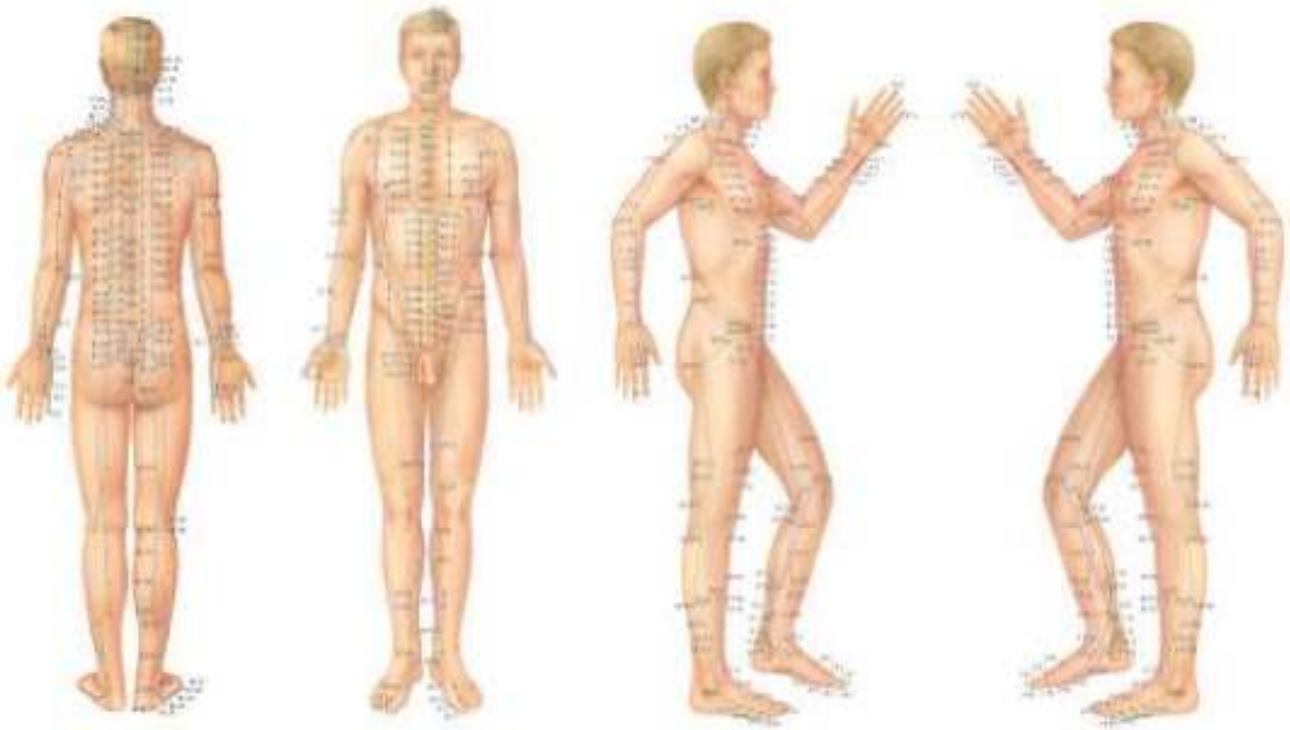
What helps your condition? \_\_\_\_\_

What aggravates your condition? \_\_\_\_\_

Please list any surgeries or major health incidents (accidents, etc.) in your life: \_\_\_\_\_

\_\_\_\_\_

**PAIN PATIENTS**, please indicate on the figures below the areas of the body you experience your pain:



How would you characterize your pain:  dull/achy  sharp/stabbing  burning  tingling  numbness  electrical

What would you like to achieve with acupuncture treatment? \_\_\_\_\_

\_\_\_\_\_

**Please check the symptoms you experience frequently:**

- hair loss
- headache
- poor memory
- muddled thinking
- ear ringing
- hearing loss
- ear pain
- blurry vision
- dizziness
- night blindness
- itchy eyes
- watery eyes
- spots before your eyes
- near sightedness
- far sightedness
- runny nose w/clear white phlegm
- runny nose w/yellow or green phlegm
- sinusitis
- allergic rhinitis (allergies)
- nose bleeds
- dry mouth
- bitter taste in mouth
- bland taste in mouth
- sour taste in mouth
- excessive thirst
- bad breath
- sore throat
- get sick frequently
- grief
- chills and fever
- sweating with little or no exertion
- I usually feel cold
- cold hands and/or feet
- I usually feel warm/hot
- face and/or body flushing/flashes
- cough
- cough w/ clear or white phlegm
- cough w/yellow or green phlegm
- shortness of breath
- chest distension/congestion
- chest pain
- fatigue
- chest pain
- heart palpitations
- insomnia
- dream-disturbed sleep
- restlessness
- anxiety
- fear
- sadness
- crying
- poor appetite
- excessive appetite
- abdominal pain
- abdominal bloating
- abdominal heaviness
- belching
- hiccups
- heartburn
- gurgling/rumbling in abdomen
- stress
- over-thinking
- worry
- nausea
- vomiting
- depression
- anger
- pain or discomfort in the ribs
- diarrhea
- diarrhea w/undigested food
- diarrhea w/burning anus
- diarrhea w/foul odor
- constipation
- dry stools
- stools in small pellets
- hemorrhoids
- blood or mucus in stool
- painful urination
- urination of blood
- dark, scanty urine
- excessive urination at night
- incontinence
- vaginal discharge
- menstrual clotting
- low back pain
- knee pain
- skin rashes
- low libido
- excessive sexual desire
- edema

