Goleta Acupuncture Wellness Clinic
New Patient Confidential Health Information

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 may feel certain questions do not pertain to your present condition. Thank you.

General Information

Name: _____ Date of Birth: _____ Today's Date _____

Home Address_____ City_____ State_____ Zip_____

Phone: _____ E-mail: _____

Patient Status: ☐ Single ☐ Married ☐ Others _____ Driver's License / SSN: _____

Current Occupation: _____

Employer _____

Employer's Adress_____

If under 18, person responsible for your account: Name _____ Phone _____

Address_____

Are you currently under the medical care of a doctor's care? ☐ Yes ☐ No

If yes, who and for what ?_____

Family Physician if different from above_____ Contact # _____

Are there any other therapies which you are involved in? _____

Emergency Contact: Name: _____ Phone:_____

Whom should we thank for referring you to our office? _____

Have you had Acupuncture before? ☐ Yes ☐ No Height: ___ft_____in or _____ cm Weight _____lbs/kg

Insurance Information

Primary Insurance Co.	Policy No.	Group No.
Primary Insurance Phone No.		
Subscriber's Name:	Date of Birth:	
Subscriber's Relationship to Patient: □ Self □ Spouse □ Child □ Others		

Secondary Insurance Co.	Policy No.	Group No.
Secondary Insurance Phone No.		
Subscriber's Name:	Date of Birth:	
Subscriber's Relationship to Patient: □ Self □ Spouse □ Child □ Others		

Medical History

Blood Type: ☐ O+ ☐ O– ☐A+ ☐A– ☐ B+ ☐B– ☐AB+ ☐AB–

What are your health concerns? _____

_____

When did it first happened? _____

What was the initial cause? _____

What makes it worse?_____

What makes it better?_____

How does this problem interfere with your daily activities:

☐ Work	☐ Standing	☐ Sexually	☐ Other
☐ Sleep	☐ Exercise	☐ Recreation	_____
☐ Walk	☐ Relationships	☐ Bending	
☐ Sitting	☐ Social life	☐ Stretching	

What have you done about this? _____

_____

Please list any surgeries or major health incidents and traumatic injuries in your life _____

_____

_____

Please indicate if any of the following applies to you:

Past	*Now*	*Condition*	*Past*	*Now*	*Condition*	*Past*	*Now*	*Condition*
☐	☐	Allergies	☐	☐	Hypothyroid	☐	☐	Drug Reaction
☐	☐	Hepatitis A, B, C	☐	☐	Hyperthyroid	☐	☐	Herbs Reaction
☐	☐	Jaundice	☐	☐	Autoimmune Disease	☐	☐	Cancer
☐	☐	Anemia	☐	☐	Diabetes	☐	☐	Chemo/Radiation
☐	☐	Heart Attack	☐	☐	High Blood Pressure	☐	☐	Epilepsy / Seizures
☐	☐	Irregular Heartbeat	☐	☐	Low Blood Pressure	☐	☐	Mental Illness
☐	☐	Hemophilia (blood-coagulation disorders)	☐	☐	High Cholesterol	☐	☐	Substance Abuse
☐	☐	Pacemaker	☐	☐	High Triglyceride	☐	☐	HIV + / AIDs
☐	☐	Other Heart Disease	☐	☐	Overweight	☐	☐	STDs
☐	☐	Measles/Mumps/Rubella	☐	☐	Obesity	☐	☐	
☐	☐	Other Childhood Disease	☐	☐	Gout	Others:		
☐	☐	TB	☐	☐	Multiple Sclerosis	☐	☐	
☐	☐	Asthma	☐	☐	Parasites	☐	☐	
☐	☐	Other Pulmonary Disease	☐	☐	Arthritis	☐	☐	

Do you have any metal piece/ machine in your body? ☐ Yes ☐ No ☐ Don't know

Dental Work: ☐ Amalgam Fillings ☐ Root Canals ☐ Others:

Smoker? ☐ Yes ☐ No ☐ Ceased years ago

Please list any nutritional supplements you are presently taking:

Supplements	Dosage	Time Taken	Reason / Purpose

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

Medication	Dosage	Time Taken	Reason / Purpose

Which of these environments affect you adversely?

□ Cold	□ Damp	□ Windy	□ Foggy
□ Heat	□ Dry	□ Humid	

Which of these environments make you feel better?

□ Cold	□ Damp	□ Windy	□ Foggy
□ Heat	□ Dry	□ Humid	

Do you have intolerance to hot or cold (food, drink, or areas of the body that are hot or cold)?

_____

Daily Habits (how much of the following substances do you consume daily?)

Coffee _____ Soda pop _____ Water _____

Alcohol_____ Recreational drugs _____ Tobacco_____

Dairy Products (milk, cheese, yogurt, butter, ice cream, etc.) _____

Meats / fish / Poultry _____

Breads & Grains _____

Cooked vegetables _____

Raw fruit /vegetables _____

Specific food /flavor cravings _____

Daily sugar content _____

Typical Day's Menus:

Breakfast _____

Lunch _____

Dinner _____

Snacks _____

Are there any foods that you are allergic or sensitive to? _____

Types of Care

Corrective Care	Maintenance Care	Wellness & Preventive Care
Chronic Symptoms and Signs Get me out of pain and discomfort first. Most patients begin acupuncture treatment o relieve pain, discomfort and other symptoms first. Acute care helps you to ease your initial problems quickly.	Symptoms and signs disappear Feeling good, no big problems! Maintenance care gives you a chance to deeper healing to occur. Strengthening your body's immunity to illness by stimulating your natural healing power.	You are feeling great! Life is wonderful! Wellness care is the best choice for people who want to achieve optimal health and well-being, free of disease and illness.

What are your health goals? ☐ Symptom Relief ☐ Deeper Healing ☐ Optimal Health

Signs & Symptoms

Digestive System

- □ Abdominal pain
- □ Acid regurgitation
- □ Vomiting
- □ Belching
- □ Hiccups
- □ Bloody stools
- □ Constipation, dry tool
- □ Heaviness
- □ Hemorrhoids
- □ Indigestion
- □ Nausea
- □ Rib or side pain
- □ Stomach ulcer
- □ Stomach pain
- □ Undigested food in stool
- □ Weight gain
- □ Poor appetite
- □ Always hungry
- □ Stomach bloating
- □ Organ prolapse
- □ Burning sensation in anus
- □ Loose stool

Urogenital

- □ Bladder/ kidney infections
- □ Bloody urine
- □ Cloudy urine
- □ Dark urine
- □ Infertility
- □ Miscarriage
- □ Low libido
- □ Wake to urinate ___x per night
- □ Frequent urination
- □ Incontinence
- □ Nocturnal emission
- □ Impotence
- □ Premature ejaculation
- □ Vaginal discharge
- □ Water retention
- □ Kidney Stone

Head

- □ Blurred vision
- □ Deafness
- □ Dizziness
- □ Ringing in ear
- □ Flushed face
- □ Headache
  - Location
  - Frequency
- □ Poor memory
- □ Poor vision
- □ Tongue or mouth sores
- □ Tooth loss
- □ Tooth abscess
- □ Swollen, bleeding gums
- □ Bad breath
- □ Thirst
- □ Hair loss

Emotions

- □ Anger, frustration
- □ Anxiety
- □ Bi-polar disorder
- □ Depression
- □ Fear
- □ Hysteria
- □ Irritable
- □ Excessive worry
- □ Sadness
- □ Grief

Sleep

- □ Difficulty falling asleep
- □ Difficulty stay in sleep
- □ Nightmares Insomnia
- □ Wake early at ____am, back to sleep at ____am
- □ Dream disturbed sleep
- □ Wake up unrested
- □ Night sweat

Dermatology

- □ Brittle nails
- □ Dry skin
- □ Itchy skin
- □ Rashes
- □ Psoriasis
- □ Acne
- □ Eczema
- □ Other (specify)

Respiratory and Chest

- □ Allergies
- □ Asthma / wheezing
- □ Sensation of object in throat
- □ Coughing
- □ Frequent colds
- □ Hard to project voice
- □ Pneumonia, bronchitis
- □ Radiating chest pain
- □ Shortness of breath
- □ Sighing
- □ Coughing or spitting up mucus
- □ Palpitations
- □ Sore throat

Musculoskeletal

- □ Achy joints
- □ Lower back pain
- □ Sore muscles
- □ Spasms
- □ Weak knees
- □ Swollen painful joints

Circulatory

- □ Always cold
- □ always hot
- □ hot/cold sensation in the body
- □ Cold limbs
- □ Cold hands and feet
- □ Symptom relieved by cold
- □ hot palms and feet
- □ symptoms relieved by heat
- □ Alternating fever and chills
- □ Stroke
- □ Blood clots
- □ bruise easily
- □ masses, lumps, or tumors
- □ numbness
- □ tingling
- □ paralysis
- □ spasms

Others

Energy Level :
- □ Normal
- □ Low /Fatigue
- □ High

Stress Level:
- □ Normal
- □ Low
- □ High

Female Concerns

Age of first period _____ Date of last period _____ Number of children (live births) _____

Number of days between periods (your cycle) _____ Number of days of flow_____

□ Peri-menopause □ Menopause

Color of flow:	**Amount of flow:**	**# of pads you use per day:**	**Pain and cramping:**	
□ pale/light red	□ spotting	1st day ____	□ No	
□ red	□ light	2ND day ____	□ Yes	
□ bright red	□ even throughout	3RD day ____	□ before flow	□ mild
□ dark red	□ heavy	4th day ____	□ during flow	□ moderate
□ dark red/brown		+ days ____	□ after flow	□ severe
□ clots				

Other symptoms related to menses:

□ Discharge	□ PMS	□ Headache	□ Nausea
□ Diarrhea	□ Swollen breasts	□ Mood swings	□ Increased appetite
□ Constipation	□ Feeling cold	□ Insomnia	□ Decreased appetite

Have you ever been diagnosed with:

□ fibrocystic breasts	□ fibroids	□ endometriosis	□ ovarian cysts
□ polycystic ovary syndrome	□ PID	□ STD _____	

Male Concerns

History of impotence, premature ejaculation, fertility difficulties, discharge form penis, vasectomy, etc. _____

_____

Others concerns _____

_____

Pain Patients

Please describe the areas of the body you experience your pain: _____

_____

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

Any additional information_____

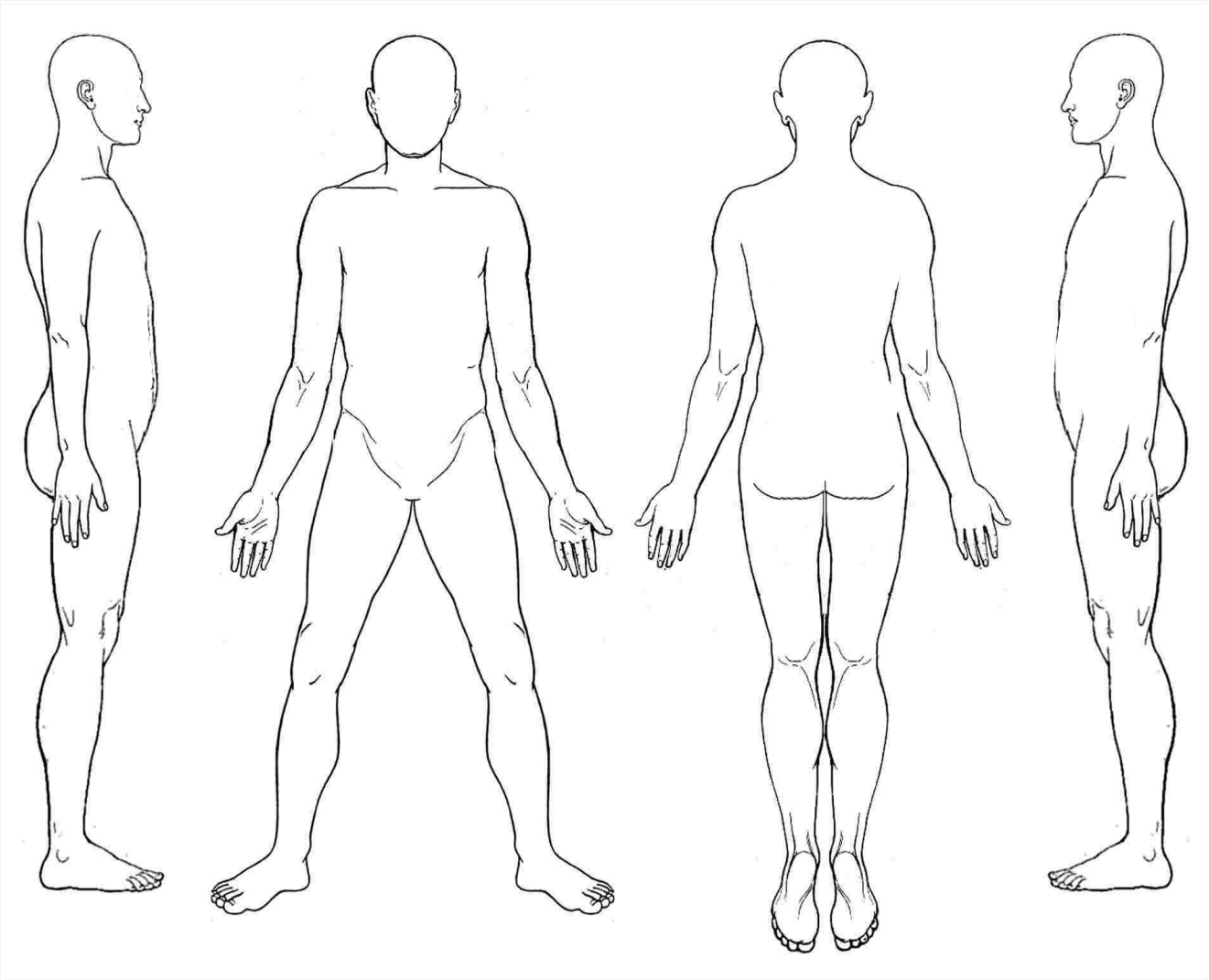
_____

_____

_____

You can also indicate on the figures below the areas of the body you experience your pain:

Numbness	= = = =	Aching	^ ^ ^ ^	Cramping	●●●●●●
Burning	x x x x	Pin & Needles	○○○○○	Stabbing	/ / / / / / /



Other Remarks: _____

_____

_____