

Name _____ Date _____

Nickname _____ Email Address _____

Would you like a reminder before your appointment? Yes No
If yes, by what method? Email Phone Call

Have you been treated by Acupuncture or Oriental Medicine Before? Yes No
If yes, what was your experience? _____

1. Goals: What would you most like to achieve through your work with this acupuncturist?

2. Main Symptoms/Problems: _____

3. When did this/these problem(s) begin? _____

4. To what extent do/does this/these problem(s) interfere with your daily activities (sleep, work, etc).

5. Have you been given a diagnosis(es) for this/these problem(s)? If so, what? _____

6. What kinds of treatment have you tried? _____

7. What is the severity of your pain level **right now**?
Less 1 2 3 4 5 6 7 8 9 10 Worst

8. Is there anything else I should know about your present condition? _____

9. What activities aggravate your condition? _____

10. Any significant trauma (auto accidents, falls, etc.) that have contributed to this condition? If so, what?

22. How much water do you drink during the day? _____
23. Have you ever been treated for mental/emotional problems? Yes No
24. Do you have any other neurological or psychological problems? Yes No
25. In the past year, how many days have been significantly affected by your health? _____
26. How many hours of sleep do you usually get per night? _____
27. Has there been any major change to your sleeping patterns (shift changes, easily awakened, snoring)?

28. Do you wake feeling rested? Yes No
29. How would you describe your social support (relationships)? _____

30. Is there anything else that I should know about your health? Yes No
If yes, what? _____

I understand it is my responsibility to inform the acupuncturist of changes to any of the above-listed items.

Patient or Guardian Signature

Date