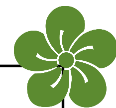

Name	
Address	
email	mobile ph
home ph	work ph
date of birth	marital status
occupation	Have you had acupuncture before? Y/N If so, with whom?
GP / family doctor	
Name and phone no. of your emergency contact person	

What's your primary reason for seeking acupuncture? ______________________________

When did this first begin? ______________________________

What was the initial cause? ______________________________

What makes it worse? ______________________________

What makes it better? ______________________________

Please circle any that apply. **This problem affects your**:
physical, emotional, mental well-being; walking, standing, sitting, lying down, bending, stretching; sleep, work life, exercise, social life, recreation, personal relationships, sexual life

How does this problem affect your life otherwise? ______________________________

____

____

Please list **previous treatments** for this, if any, and which have helped (+) and which didn't (-):

____

Please circle any that apply. Are you **interested in**:
Pain relief, preventative health care, holistic health, stress relief, herbal therapy, Oriental nutrition, personal development, spiritual development, other

What are **your health goals**? ______________________________

____

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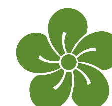

How are your **energy levels**? Great / OK / Fluctuating / Poor / What's energy?

Do you have a **high point** during the day? Y/N When?

Do you have a **low point** during the day? Y/N When?

Do you **sleep** well? Y/N Do your dream? Y/N

Recurring themes?

Do you drink **tea or coffee**? Y/N If so, how many cups per day?

Do you drink **alcohol**? Y/N If so, how many standard drinks per week/day?

Do you **smoke**? Y/N If so, what and how much per day?
Do you want to quit? Y/N

Do you have any allergies? Y/N If so, to what?

Do you take **supplements**? Y/N If so, what types and how often?

Do you take **medication**? Y/N
If so, what types and how often? Please include laxatives, painkillers, sleeping pills, herbal remedies and/or any self-prescribed medication: ______________________________

____

Please list any **medication you've had to take for a long time** (months/years) in the past:

____

Do you follow a special **diet** (e.g. vegetarian, vegan, low-fat, low-carb, etc.)? Y/N
If so, what do or do you not eat (whichever is easier to write out)? ______________________________

____

Do you have a **regular relaxation or mindfulness practice** (e.g. meditation, yoga, tai chi, qigong)? Y/N

What kind of **exercise or sports activities** are have you been or are you currently involved in? _______

____

What are your **hobbies / pleasures / passions**? ______________________________

____

Female concerns:
Is your cycle regular? Y/N
Average length of your cycle:
Day 1 of your last menstruation:
Average length of your menstruation:
Is your period painful? Y/N
Is there clotting? Y/N
Do you take contraceptives? Y/N
If yes, for how long?
Have you ever been pregnant? Y/N
Number of pregnancies:
Number of live children:

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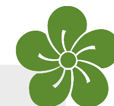

Signs / Symptoms

Please (circle all that apply now) and underline all that applied in the past, or use two different-coloured pens.

General: Fatigue, lack of energy, sudden energy drops, shortness of breath, poor sleep, insomnia, nightmares, night sweats, snoring, travel sickness, unusual perspiration, no perspiration at all, sweat easily, hair loss, unintended weight loss, unintended weight gain, overweight, underweight, heavy drinking, smoking, more than 3 cups of coffee a day, poor appetite, always hungry, always thirsty, peculiar tastes, sweet cravings, other food cravings, excessive phlegm, tumours, cancer

Head: headaches, migraines, dizziness / vertigo, concussion, loss of hair, premature greying of hair

Mental / emotional / nervous system: moodiness, irritability, excessive worrying, poor memory, dyslexia, anxiety, fearfulness, phobias, nervousness, always high-strung, can't say no, hard to relax, melancholy, grief, sadness, loss of interest in activities you used to enjoy, poor concentration, frequent lateness, stuttering, confusion, depression, short temper, outbreaks of rage, seeing a therapist, seizures, epilepsy, bipolar disorder, OCD, ADD, ADHD, PTSD, MND, ALS, drug addiction, alcoholism, abuse survivor, other

Mouth: dry mouth / throat, metallic / bitter / sour / foul taste in mouth, halitosis (bad breath), bad teeth, bleeding gums, abscesses, mouth ulcers, inflammations, others, cold sores, jaw joint pain, cracking jaw joint, grinding teeth, salivary gland inflammation, missing teeth, root canal treatment, amalgam / gold fillings, crowns, inlays, bridges, false teeth, braces

Ears: poor hearing, deafness, tinnitus (ringing in ear), itching of ear canal, frequent ear infections, ear aches, other

Nose: poor sense of smell, congested nose, runny nose / clear discharge, yellow/green phlegm, recurring sinus infections, polyps, post nasal drip, nose bleeds, cold sores, other

Eyes / vision: poor vision, short-sighted, far-sighted, astigmatism, blurred vision, dry eyes, itchy eyes, red eyes, floating spots in vision, wind sensitivity, light sensitivity, night blindness, cataracts, glaucoma, other

Skin: Eczema, acne (pimples), dry skin, oily skin, itchy skin, neurodermatitis, psoriasis, warts, abscesses, rash, fungal infection, athlete's foot, nail infection, other

Respiratory system: Cough, shortness of breath, asthma, wheezing, bronchitis, pneumonia, frequent colds, frequent tonsillitis / sore throat / strep throat, emphysema, lung abscesses, tuberculosis, whooping cough, coughing blood, other

Digestive system: Constipation, diarrhoea, dark stools, very smelly stools, blood in stools, mucous on/in stools, irritable bowel syndrome, intestinal cramping, loss of appetite, bloating, gas, belching, tiredness after eating,no appetite in the morning, hiccups, abdominal cramping / pain, food allergies or intolerances, abdominal distension, heartburn, acid regurgitation, vomiting, stomach or duodenal ulcers, gastritis, lack of stomach acid, pancreatitis, gallstones, hepatitis, liver cirrhosis, gallbladder disease, laxative use, haemorrhoids, other

Urinary system: UTIs (urinary tract infections), kidney stones, incontinence, pain when urinating, difficulty urinating, blood in urine, too frequent urgent urination, wake at night to urinate, urinary reflux, bladder weakness, other

Heart and circulation: fast pulse (resting pulse rate over 100 bpm), slow pulse (less than 60 bpm), palpitations, heart arrhythmia, chest pain or tightness, high blood pressure, low blood pressure, stroke, constantly feeling hot, constantly feeling cold, cold hands, cold feet, burning hands, burning feet, afternoon/evening fevers, constant low-grade fever, blushing, hot flushes, anaemia, dizziness when standing up, fainting spells, bruise easily, numbness or tingling sensations, other

Hormone system: Diabetes, low blood sugar level, enlarged thyroid, hypothyroidism, hyperthyroidism, other

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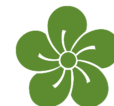

Female Reproductive System: Problems before, during or right after periods: abdominal pain, cramping, back pain, irritability, breast pain. Irregular or absent menstruation, spotting between periods, lack of sexual desire, too much sexual desire, vaginal discharge, vaginal itching, vaginal pain, endometriosis, tubal sterilisation, hysterectomy, infertility, pregnancy termination, miscarriage, C-section, perineal tear or cut, breast lump, breast pain, other

Male Reproductive System: Lack of sexual desire, too much sexual desire, infertility, impotence, vasectomy, premature ejaculation, nocturnal emissions, enlarged prostrate, discharge, itching, other

Immune system: Rheumatic diseases, arthritis, fibromyalgia, chronic fatigue, frequent colds, ulcerative colitis, morbus crohn, coeliac disease, “hay fever”, chronic low grade fever, swollen glands/lymph nodes, measles, mumps, chicken pox, shingles, scarlet fever, multiple sclerosis, fibromyalgia, chronic fatigue syndrome, syphilis, gonorrhoea, herpes, HIV/AIDS, other

Muscles, joints and bones: Injuries to joints, bones, muscles, ligaments or sinews, tailbone, spine, neck, skull. Pain in joints, bones, muscles, ligaments or sinews, tailbone, spine, neck, skull. Muscle cramps, limited range of motion, tight neck/shoulders, lower back pain, lumbar prolapse / herniated disc, sciatica, weak legs, leg length difference, RSI/OOS, other

Please list **all scars** (even small and old ones)**, tattoos and piercings** , and mark vaccination scars with a star*: ____

____

____

The following things can affect one’s health, even long after they are over. Please list briefly whatever applied/applies to you

1. Any pregnancy or birth complications (ask your mother if possible)
2. Issues that affect the whole family: Absence or illness of family members, addictions of any kind, psychological illness, (attempted) suicide, physical, sexual or emotional abuse, emotional neglect, etc.[1]
3. Unusual course of children’s diseases and complications from vaccinations
4. Any serious or recurring disease
5. Psychological issues, mobbing, traumatic or unsettling experiences
6. Accidents (including sports accidents)
7. Surgeries and other invasive procedures
8. Recreational drug use (past or present)

____

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Your family’s medical history: Please indicate if any of your family members have or had any of the following conditions:
Anemia, blood transfusion, heart attack, heart disease, high blood pressure, low blood pressure, arthritis, gout, obesity, diabetes, drug reaction, parasites, pneumonia, tuberculosis, jaundice, hepatitis, syphilis, gonorrhoea, herpes, HIV/AIDS, cancer, hypo/hyperthyroid, premature greying of hair, epilepsy, seizures, multiple sclerosis, mental illness, mental breakdown

[1] You do not have to write these down if you feel uncomfortable doing so, but please make a mental note to mention these event(s) to me in person. Due to the whole-person approach of acupuncture, many health problems resulting from emotional and mental suffering can be alleviated without your having to go into details.

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