Healing Path of Rockford
695 N. Perryville Rd Ste 1
Rockford, IL 61107
Phone: (815) 977-5480
Fax: (815) 977-3479

Acupuncture Patient Questionnaire

Name:_____ Today's Date:_____
Address:_____ City:_____ State:_____
Zip:_____ E-mail address:_____
Phone-Home:_____ Work:_____ Cell:_____
Birth Date: _____ Age:_____ Height: _____ Weight:_____ Sex: M / F
Marital Status: _____ No. of Children:_____ Occupation:_____
Emergency Contact - Name: _____ Phone: _____
Primary Care Practitioner:_____

Is this your first time receiving acupuncture? **Y** / **N**

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)

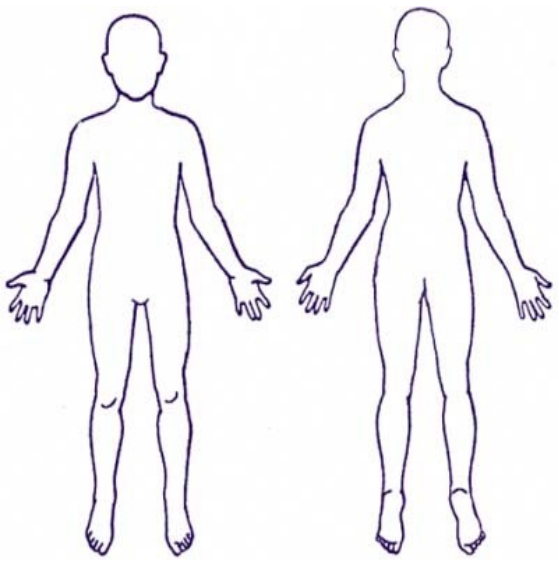
_____
_____
_____

Are you experiencing pain/discomfort in any area of your body? **Y / N**

Please rate your overall pain level:
(1 is low & 10 is high)
1 2 3 4 5 6 7 8 9 10

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/Achy
N Numbness
T Tightness/Spasms



Medical History
Do you or have you had any of the following conditions? If yes, please indicate date of diagnosis.

Cancer (specify type): _____
HIV _____
Diabetes 1 / 2: _____
Mental Illness _____
Heart Disease _____
Seizures _____
Hepatitis _____
Stroke _____
Blood Pressure _____
Thyroid Disease _____
High Cholesterol _____
Other _____

Please list any surgeries or major injuries with dates.
_____
_____
_____

List any medications or supplements or herbs you have taken in the last 2 months.
_____
_____
_____

Do you have a pacemaker or any metal devices in your body? **Y / N**
Explain_____

Family History
Indicate close family members with any of the following.

Cancer (specify type): _____
High Cholesterol _____
Diabetes 1/2: _____
Mental Illness _____
Heart Disease _____
Stroke _____
Blood Pressure _____
Alcoholism _____

Lifestyle Habits
Do you have an exercise routine? Please describe.
_____
_____
How many hours per night do you sleep on average? _____ Do you wake rested? **Y / N**
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 and type of food)
_____
_____

Please check all that apply

Energy and Immunity

__ Fatigue __ Anemia __ Tendency to Catch Colds
__ Thyroid Problems_____ __ Allergies (Specify) _____

Head, Eye, Ear, Nose, and Throat

__ Watery eyes __ Teeth Grinding / TMJ __ Increase in Thirst
__ Eye Dryness __ Hearing Difficulties __ Dry Mouth
__ Ear Ringing __ Sore Throat __ Bad Breath
__ Mouth Sores __ Blurry Vision __ Headache/Migraine
__ Sinus Congestion

Emotions / Sleep

__ Mood Swings __ Anxious / Worried __ Stressed
__ Depressed __ Irritable __ Insomnia
__ Nightmares __ Difficulty Making Decisions
__ Difficulty Sleeping (Falling Asleep/Staying Asleep/Waking up throughout night and what times) _____

Respiratory/Cardiovascular

__ Asthma __ Chronic Cough __ Unusual Sweating
__ Chest Pain __ Hot/Cold Intolerance __ Poor Circulation (Cold hands/feet)
__ Shortness of Breath __ Palpitations/Fluttering __ Night Sweats

Gastrointestinal

__ Ulcers __ Gas __ Diarrhea
__ Changes in Appetite __ Nausea/Vomiting __ Sudden Weight Change
__ Heartburn/Reflux __ Belching __ Hemorrhoids
__ Constipation (How often are stools passed a week?) _____

Kidney/Urinary

__ Painful Urination __ Edema / Swelling __ Frequent Urinary Tract Infections
__ Frequent / Urgent Urination

Musculoskeletal

__ Neck Pain __ Upper Back Pain __ Mid Back Pain
__ Low Back Pain __ Leg / Knee Pain __ Foot / Ankle Pain
__ Arm Pain __ Arthritis __ Hip / Pelvic Pain
__ Shoulder Pain __ Muscle Spasms / Cramps / Weakness
__ Finger Pain / Tingling / Numbness

Neurological

__ Vertigo / Dizziness __ Numbness / Tingling __ Difficulty Concentrating / Poor Memory

Skin

__ Dry Hair/Hair Loss __ Changes in Skin Color __ Dry / Itchy Skin
__ Easy Bruising __ Acne __ Rashes / Eczema / Hives / Psoriasis

Male Health

__ Prostate Enlargement __ Decreased Libido __ Impotence
__ Groin Pain

Female Health

__ Irregular Cycle __ Clots in Menstrual Blood __ Menstrual Related Bloating
__ Vaginal Dryness __ Endometriosis __ Frequent Yeast Infections
__ Heavy Flow __ Ovarian Cysts __ Menstrual Relates Moodiness
__ Decreased Libido __ Breast Lumps/Cysts __ Bleeding Between Cycles
__ Light Flow __ Hot Flashes __ Uterine Fibroids
__ PCOS __ Unusual Vaginal Odor __ Difficulty Conceiving
__ Menstrual Related Breast Tenderness
__ Painful Periods (Is pain before, during and/or after period?) _____

Women Only

Pregnant **Y/N** How many weeks? _____
Number of children _____ Number of pregnancies _____
Age of first menstruation _____ Average # of days of flow _____
Average # of days of cycle _____ Age of menopause _____

_____
_____
_____
_____
_____
_____