507 S Fitness Plaza, Ste 100, Eagle, ID 83616 (208)-938-1277 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 _____ Mobile _____ E-mail _____

How exactly did you hear about 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

Vitamin supplements are an important component of a healthy lifestyle. Please check all that you are currently taking:

□ Multi-vitamin If yes, what brand? _____

□ Calcium	□ Phytonutrient	□ Vitamin C
□ Vitamin E	□ Vitamin D	□ Probiotic
□ Omega-3	□ Zinc	□ B Complex

□ Herbs If yes, which ones? _____

□ Other Please explain _____

Medications	Reasons for taking

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? _____

_____

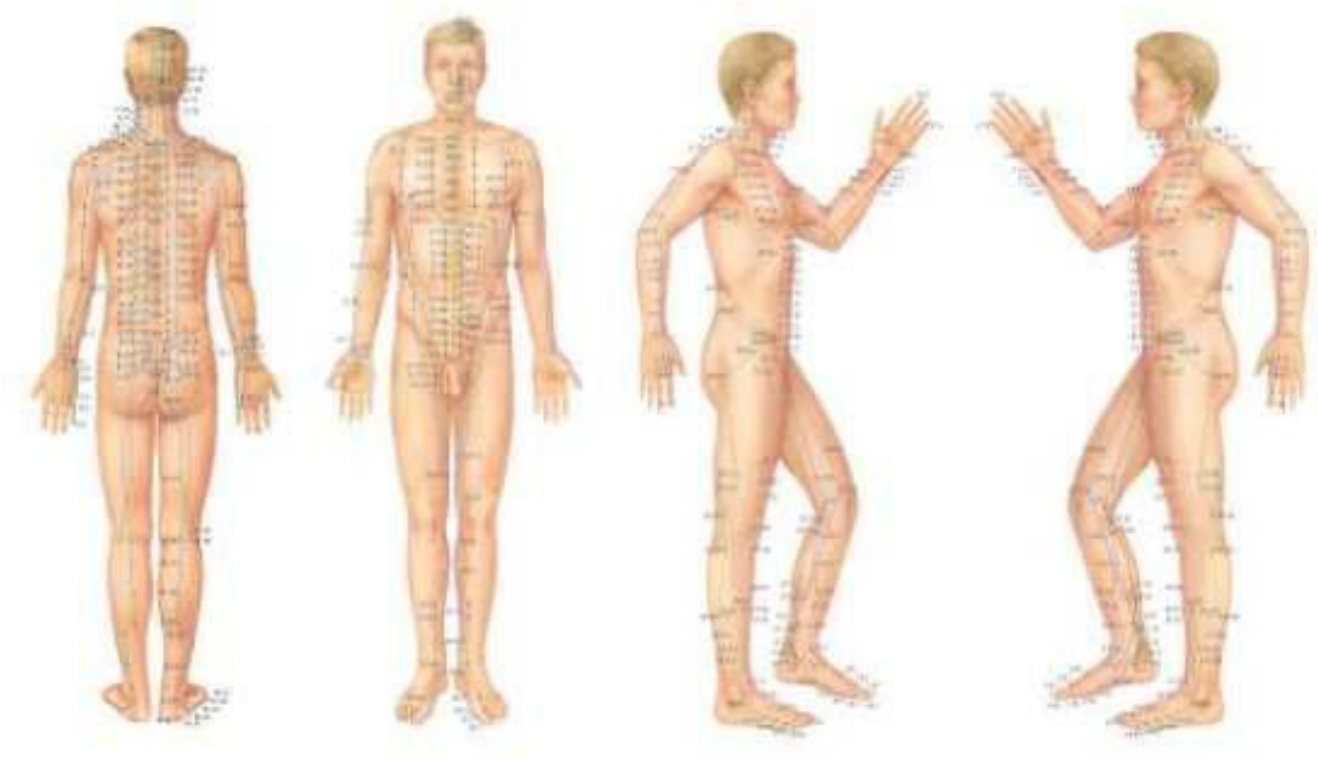
What helps your condition? _____

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 <u>frequently</u>:

□ 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