

## Acupuncture of Reston – New Patient Information Form

Please help us provide you with a complete evaluation by taking the time to fill out this questionnaire carefully. All answers are confidential. Please print clearly in ink.

Name \_\_\_\_\_ Sex M \_\_\_ F \_\_\_ Date \_\_\_\_\_ Email \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Date of Birth \_\_\_\_\_ Place of birth \_\_\_\_\_ Age \_\_\_ Height \_\_\_ Weight \_\_\_

Telephone: Home ( ) \_\_\_\_\_ Work ( ) \_\_\_\_\_ Cell ( ) \_\_\_\_\_

\_\_\_ Single \_\_\_ Married \_\_\_ Divorced \_\_\_ Widowed \_\_\_ Living with

Education \_\_\_\_\_ Occupation \_\_\_\_\_

Referred by: \_\_\_\_\_

Reason for visit today \_\_\_\_\_

Other problems \_\_\_\_\_

How long have you had this condition? \_\_\_\_\_ Have you ever experienced this before? \_\_\_\_\_

What seemed to be the initial cause? \_\_\_\_\_

What seems to make it better? \_\_\_\_\_

What seems to make it worse? \_\_\_\_\_

Does it bother your Sleep \_\_\_ Work \_\_\_ other (what?) \_\_\_\_\_

**FAMILY HISTORY** - Complete for each family member, indicating any of the illnesses that they have ever had. Place an "X" in the appropriate box or boxes.

|                                    | self | mother | father | sibling | spouse | children |
|------------------------------------|------|--------|--------|---------|--------|----------|
| cancer or tumors                   |      |        |        |         |        |          |
| diabetes                           |      |        |        |         |        |          |
| blood or bleeding disorders/anemia |      |        |        |         |        |          |
| seizures                           |      |        |        |         |        |          |
| high blood pressure/heart disease  |      |        |        |         |        |          |
| allergies                          |      |        |        |         |        |          |
| stroke                             |      |        |        |         |        |          |
| drug abuse                         |      |        |        |         |        |          |
| depression or mental illness       |      |        |        |         |        |          |
| age of death                       |      |        |        |         |        |          |
| hepatitis                          |      |        |        |         |        |          |
| kidney disorders                   |      |        |        |         |        |          |
| thyroid disorders                  |      |        |        |         |        |          |
| musculo-skeletal disorder          |      |        |        |         |        |          |
| blood transfusion (if before 1985) |      |        |        |         |        |          |

**PERSONAL LIFESTYLE HABITS** (how much, how many, or how often)

Cigarettes (packs) \_\_\_\_\_ Coffee/Tea (cups) \_\_\_\_\_ Alcohol (drinks per week) \_\_\_\_\_

Marijuana \_\_\_\_\_

Other recreational drugs \_\_\_\_\_

Vitamins & herbs \_\_\_\_\_

Dietary restrictions \_\_\_\_\_

Food cravings \_\_\_\_\_

Diet: What might you eat on a typical day?

Breakfast \_\_\_\_\_

Lunch \_\_\_\_\_

Dinner \_\_\_\_\_

Snacks \_\_\_\_\_

Exercise \_\_\_\_\_ How often? \_\_\_\_\_

What non-work activities do you enjoy doing? (reading, TV, meditation, music, etc.) \_\_\_\_\_

\_\_\_\_\_

**MEDICINES:**

Prescription drugs you are currently taking:

For what condition?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Over-the-counter medication you are currently taking:

For what condition?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**MAJOR HOSPITALIZATIONS** If you have ever been hospitalized for any serious medical illness or operation, write the most recent one below: (do not include normal pregnancies).

| YEAR | OPERATION/ ILLNESS |
|------|--------------------|
|      |                    |
|      |                    |
|      |                    |

Date of last physical examination: \_\_\_\_\_

Name & address of physician \_\_\_\_\_

Phone number of physician \_\_\_\_\_

Have you ever been treated with acupuncture &/ or Chinese herbal medicine before? Yes/No

**GYNECOLOGY**

Age of first menses: \_\_\_\_\_ Date of last menstrual period: \_\_\_\_\_ Duration of flow \_\_\_\_\_

Blood clots: yes/when: \_\_\_\_\_ Length of cycle \_\_\_\_\_

Color of menstrual blood: pale/bright red/dark red/brown other \_\_\_\_\_

Texture of menstrual blood: thick/thin/watery/normal

Pain: yes/when: \_\_\_\_\_

Irregular periods (describe): \_\_\_\_\_

PMS (please describe): \_\_\_\_\_

Current method of contraception: \_\_\_\_\_ Past method of contraception: \_\_\_\_\_

Are you currently pregnant? yes/no

Number of pregnancies:

Number of live births:

Number of miscarriages:

Number of abortions:

Any premature births:

Breast (lumps, cysts, tenderness, etc.): \_\_\_\_\_

Urinary tract infections: \_\_\_\_\_ How frequent? \_\_\_\_\_

Vaginal infections/ discharges (describe color): \_\_\_\_\_

Pain/itching of genitalia: \_\_\_\_\_

Pap smear: normal/abnormal Date of last Pap smear: \_\_\_\_\_

Uterine fibroids: \_\_\_\_\_ Endometriosis: \_\_\_\_\_ Other: \_\_\_\_\_

Menopause (date of onset): \_\_\_\_\_ Symptoms: \_\_\_\_\_

Any bleeding since? \_\_\_\_\_

Are you currently on Hormone Replacement Therapy (HRT)? yes/no Dose: \_\_\_\_\_

How long have you been on HRT? \_\_\_\_\_ Any side effects? \_\_\_\_\_

Other: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Please put a **"C"** if the condition is current or a **"P"** if you had it in the past

### General

- Insomnia
- Dreams/ nightmares
- Irritability
- Depression
- Mood swings
- Fatigue
- Poor memory
- Strongly like cold drinks
- Strongly like hot drinks
- Recent weight loss/gain
- Cold hands & feet
- Chills
- Fever

### Head & Neck

- Headaches
- Migraines
- Stiff neck
- Dizziness
- Fainting
- Swollen glands

### Ears

- Ringing
- Hearing loss
- Infections
- Earache
- Hearing aids
- Vertigo

### Eyes

- Glasses/ contact lenses
- Blurred vision
- Poor night vision
- Spots or floaters
- Eye inflammation
- Double vision
- Glaucoma
- Cataracts

### Nose, Throat & Mouth

- Sinus infection
- hay fever/ allergies
- Frequent sore throat
- difficulty swallowing
- Mouth & tongue ulcers
- Frequent colds
- Nosebleed
- Dry nose
- Nasal congestion
- Loss of voice
- Thirst
- Excessive phlegm
- TMJ
- Facial pain
- Gum problems
- Dry mouth

### Skin

- Hives
- Rashes
- Eczema/ psoriasis
- Night sweating
- Excess sweating
- Dry skin
- Easy bruising
- Changes in moles, lumps
- Itching

### Respiratory

- Difficulty breathing
- Difficulty breathing when lying down
- Wheezing
- Asthma
- Chronic cough
- Wet cough
- Dry cough
- Coughing up phlegm
- Coughing up blood
- Shortness of breath
- Tight chest
- Pneumonia

### Cardiovascular

- High blood pressure
- Low blood pressure
- Chest pain or tightness
- Palpitation
- Rapid heart beat
- Irregular heart beat
- Poor circulation
- Swollen ankles
- Phlebitis
- Anemia
- History of heart attack

### Gastrointestinal

- Nausea
- Indigestion
- Stomach pain
- Diarrhea
- Constipation
- Poor appetite
- Excessive hunger
- Vomiting
- Gas
- Hiccups
- Acid regurgitation
- Bloating
- Bad breath
- Laxative use
- Bloody stool
- Mucus in stool
- Hemorrhoids
- Gall Bladder disorder

### Musculoskeletal

- Joint pain/disorder
- Sore muscles
- Weak muscles
- Difficulty walking
- Neck/shoulder pain
- Upper back pain
- Lower back pain
- Rib pain
- Limited range of motion
- Other (describe)

### Neurological

- Seizures
- Tremors
- Numbness or tingling
- Pain
- Paralysis
- Poor coordination
- Other (describe)

### Genito-urinary

- Pain on urination
- Frequent urination
- Urgent urination
- Blood in urine
- Unable to hold urine
- Incomplete urination
- Bedwetting
- Wake to urinate
- Increased libido
- Decreased libido
- Kidney stones
- Impotence
- Premature ejaculation
- Nocturnal emission
- Pain/itching of genitalia
- Lumps in testicles

### Infection Screening

- HIV risks: self or partner
- TB: self or household
- Hepatitis risk: self or partner
- History of sexually transmitted disease: self or partner
- Gonorrhea
- Chlamydia
- Syphilis
- Genital warts
- Herpes: oral/ genital

### Other

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