The Acupuncture Clinic, LLC

Tara Heinrich L.Ac, LMT
Parker / Castle Pines, CO

This is a CONFIDENTIAL questionnaire to help us determine the best treatment plan for you. We are committed to providing you the best medical care possible.

Name ____
Age__________ Date of Birth ____________________
Address ____
City _________________ State _____ Zip ______
Email ____
Marital Status □ Single □ Married

How did you hear about us?
□ Friend □ Ad □ Website □Doctor □ Other _________

Date____
Occupation ____________________________________
Home Phone ____________________________________
Cell Phone ____________________________________
Work Phone ____________________________________
Age ________ Height __________ Weight _______
# of Children ____________________________________
Your preferred phone # □ Home □ Work □ Cell
May we leave a message? □ Yes □ No

Emergency Contact ______________________________
Phone Number ___________________________________

Relationship _____________________________________
Have you ever had Acupuncture before? Yes No

What is your primary reason for coming in for treatment?

____

When did this begin? (Please be specific.)

____

____

What do you think caused it? Is the cause still present?

____

____

Have you been given a diagnosis for this condition? If so, please list:

____

____

What kind of treatments have you tried? What were the results?

____

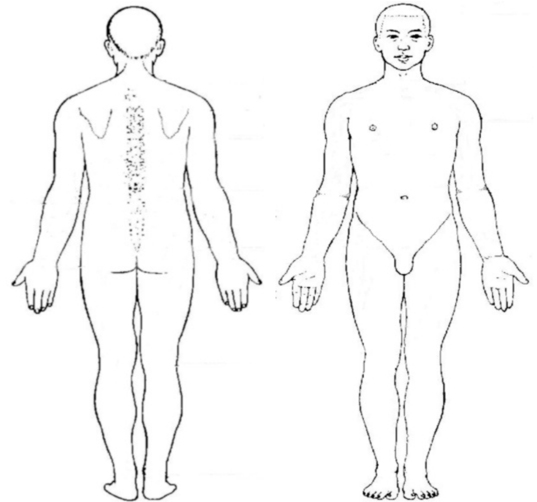
____

To what extent does this condition interfere with your daily activities (e.g. work, sleep, eating, sex, etc.)?

____

____

The Acupuncture Clinic, LLC



Please note the degree of severity of your problem now:

|____________________|____________________|

No problem Moderate Worst Imaginable

Please note the greatest degree of severity of your problem within the last week:

|____________________|____________________|

No problem Moderate Worst Imaginable

Please indicate painful or distressed areas on the diagrams to the right ->

Past Medical History (please indicate by date):

Cancer: ______________ Pacemaker: ______________ High Blood Pressure: ______________

Diabetes: ______________ Rheumatic Fever: ______________ Stroke: ______________

Hepatitis: ______________ Heart Disease: ______________ STD: ______________

Please list any hospitalizations and/or surgeries/injuries/accidents:

Hospitalization/Surgery/Accident/Injury	Date	Reason / Relation to health concerns

Please list all prescription and over-the-counter medications you are currently taking:

Name	Dosage	Reason for taking	Date began taking

Please list all vitamins, supplements, herbs, performance enhancing aids and/or weight loss products:

Name	Dosage	Reason for taking	Date began taking

Occupational Stress (physical, chemical, psychological, etc.):

____

____

Do you exercise regularly? Y / N Please describe activity:

____

THE ACUPUNCTURE CLINIC, LLC

Last Physical Date: __________ Doctor: ________________________ Results: ____________________

Habits Please indicate below: None, Light, Moderate, or Heavy. Please add comments where significant.

	Excessive	Moderate	Minimal	None	
Alcohol:	☐	☐	☐	☐	____________
Coffee / Tea:	☐	☐	☐	☐	____________
Tobacco:	☐	☐	☐	☐	____________
Exercise:	☐	☐	☐	☐	____________
Sleep:	☐	☐	☐	☐	____________
Appetite:	☐	☐	☐	☐	____________
Energy Level:	☐	☐	☐	☐	____________
Medication:	☐	☐	☐	☐	____________
Vitamins:	☐	☐	☐	☐	____________
Food Intake:	☐	☐	☐	☐	____________
Drugs:	☐	☐	☐	☐	____________
Salt Intake:	☐	☐	☐	☐	____________
Stress Level:	☐	☐	☐	☐	____________
Other:	☐	☐	☐	☐	____________

Diet Please give a general description of the food you eat during a "typical" day.

Morning: ____

Afternoon: ____

Evening: ____

Between meals: ____

What allergies do you have? What reactions do you have to these chemicals, foods, drugs, animals, etc.?

____

____

Family Health History (Parents and Siblings)

- ☐ Arthritis
- ☐ Asthma
- ☐ Alcoholism
- ☐ Alzheimer's disease
- ☐ Cancer
- ☐ Depression
- ☐ Diabetes
- ☐ Drug Addiction
- ☐ Eating Disorder
- ☐ Genetic Disorder
- ☐ High Blood Pressure
- ☐ Heart Disease
- ☐ Infertility
- ☐ Learning Disabilities
- ☐ Mental Illness
- ☐ Migraine headaches
- ☐ Parkinson's
- ☐ Obesity
- ☐ Osteoporosis
- ☐ Stroke
- ☐ Suicide

The Acupuncture Clinic, LLC

Survey of Symptoms: Please check current symptoms (** the ones that occur frequently, and write "past" next to those conditions which you have only had in the past and are no longer present).

LIVER / GALLBLADDER
____ Irritability/Anger
____ Depression/Stress
____ Headaches/Migraines
____ Visual Problems
____ Red/Dry/Itchy Eyes
____ Gall Stones
____ Dizziness
____ Feeling Lump in the Throat
____ Clenching Teeth at Night
____ Muscle Cramping/ Twitching
____ Tension
____ Joints/Neck/Shoulder Tight
____ Poor Circulation
____ Soft/Brittle Nails
____ Emotional Eater

LUNG / LARGE INTESTINE
____ Dry Cough
____ Cough with Sputum
____ Nasal Discharge
____ Post-Nasal Drip
____ Sinus Infection/Congestion
____ Itchy, Red or Painful Throat
____ Dry Mouth/Throat/Nose
____ Skin Rashes/Hives
____ Snoring
____ Grief /Sadness
____ Shortness of Breath
____ Allergies/Asthma
____ Low Resistance to Cold or Flu
____ Sneezing

SPLEEN / STOMACH
____ Heaviness anywhere in the Body
____ Fatigue/ Worse After Eating
____ Hard to Get Up in the Morning
____ Edema (Swelling)
____ Muscles Feel Tired Often
____ Bruise/Bleed Easily
____ Bad Breath
____ Decreased/Increased Appetite
____ Crave Sweets
____ Hypoglycemia
____ Difficulty Digesting Oily Foods
____ Nausea/Vomiting
____ Gas/Belching
____ Hemorrhoids
____ Constipation/Diarrhea
____ Indigestion/Heart Burn
____ Gain Weight Easily
____ Foggy Brain
____ Over-Thinking
____ Abdominal Pain

OTHER
____ Anxiety
____ Emotional Trauma
____ Depression

HEART / SMALL INTESTINES
____ Heart Palpitations
____ Chest Pain
____ Insomnia/Sleep Problems
____ Easily Startled
____ Restlessness/Agitation
____ Vivid Dreams
____ Lack of Joy in Life

KIDNEY / URINARY BLADDER
____ Urinary Problems
____ Bladder Infections
____ Lack of Bladder Control
____ Weakness/Pain in Low Back
____ Decreased Bone Density
____ Feel Cold Easily
____ Low Sex Drive
____ Excess Sexual Desire
____ Poor Memory
____ Loss of Hair
____ Hearing Problems
____ Cavities
____ Craving/Avoiding Salty Foods
____ Fear
____ Hot Flashes/Night Sweats

Is there anything else you would like to share with us? ____

Patient Signature ____ Date ____________________