Sage Acupuncture 4469 Morrell Street Pacific Beach, CA 92109 858-272-7330

This is a CONFIDENTIAL questionnaire to help us determine the best treatment plan for you. Please fill it out as completely as possible.

Personal Information

Name _____ Age _____ DOB _____

Home Address_____

City_____ State_____ Zip_____

Best Phone _____

E-mail (Periodic Informational Emails are sent out): _____

Whom should we thank for referring you to our office? _____

Have you had acupuncture therapy before? □ Yes □ No Insurance Carrier: _____

General 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? _____

How would you characterize your pain: □ dull/achy □ sharp/stabbing □ burning □ tingling □ numbness □ electrical

If you experience pain, on a scale from 1-10, 10 being the worst, how would you rate your pain: _____/10

Please list any surgeries or major health incidents (accidents, etc.) in your life:_____

_____

How would you rate your overall health (Please Circle): Poor Good Great

How do you think you could improve your overall health: _____

Please indicate if any of the following pertain to you:

□ Hepatitis □ HIV □ High Blood Pressure □ Seizures □ Pacemaker □ Blood-Thinning Meds □ Pregnancy

Please indicate the use and frequency of the following:

Coffee _____ Soda pop _____ Water _____

Alcohol_____ Recreational drugs _____ Tobacco _____

Please list any prescription or over-the-counter medications you are presently taking:

Medication	Reason
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Symptom Survey

Please check the symptoms you have had or are currently experiencing:

__ excessive appetite
__ lack of appetite
__ loose stool/diarrhea
__ bad breath
__ vomiting
__ heartburn/reflux
__ stomach bloating
__ obsession in work, relationships, etc.
__ bruise easily
__stomach or abdominal pain

__ insomnia
__mouth sores
__ palpitations
__ cold hands and feet
__ nightmares
__ mentally restless
__ chest pains
__ poor memory
__urinary infection

__ cough
__ sadness
__ shortness of breath
__ decreased sense of smell
__ nasal problems
__skin problems
__allergies
__frequent colds

__ low back pain
__knee problems
__change in hearing
__ ear ringing
__kidney stones
__decreased sex drive
__hair loss
__ urinary problems
__joint pain

__ eye problems
__jaundice
—difficulty digesting oily foods
__easily angered
__gall stones
__soft or brittle nails
__constipation
__bitter taste in mouth
__ difficulty in making decisions
__headache

Other:

_____

♀For Women

Age of first period _____ Date of last period _____ Number of pregnancies _____

Number of days between periods (your cycle) _____ Number of days of flow_____

Color of flow:

□ pale/light red
□ □ red
□ bright red
□ dark red
□ dark red/brown □ clots

Amount of flow:

□ spotting
□ light
□ even throughout
□ heavy

Other symptoms related to menses: □ Discharge □ Headache □ Nausea □ Bleeding between periods

□ Constipation □ Diarrhea □ Swollen Breasts □ Mood Swings □ Changes in Appetite □ Insomnia

Any recent changes in your menstrual cycle? _____

Do you bleed after intercourse? _____

Have you ever been diagnosed with: □ Fibroids □ Fibrocystic breasts □ Endometriosis □ Ovarian cysts □ PID

□ Polycystic Ovary Syndrome □ STD _____ □ Other_____

Fertility Information

How long have you been trying to actively conceive? _____ Have you and your partner discussed your alternatives? _____

# of IVF procedures _____ # of IUI procedures _____

Has a physician diagnosed a difficulty with fertility due to: □ Female Factor □ Male Factor □ Unexplained

Do you keep a regular BBT Chart? _____

Has your partner or donor had his sperm evaluated? _____

Have you had recent hormone lab work? _____

Have you ever been on Birth Control and if so how long did you use stand when did you stop? _____

Conclusion

Are you interested in additional health services besides acupuncture? □ No □ Yes

Please check which services you would be interested in: □ Chinese herbal medicine □ Therapeutic massage

□ Tai chi □ Qi gong health exercises □ Relaxation techniques □ Nutritional consultation