DHARMA ACUPUNCTURE & YOGA
Patient Questionnaire

Name _____ Date _____
Address _____
City _____ State _____ Zip _____
Home Phone _____ Cell Phone _____ Work Phone _____
Occupation _____ Employer _____
Date of Birth _____ Birthplace _____
Email Address _____ Referred By _____
Marital Status _____ Number of Children _____

List any medications you are taking _____

List any surgeries you have had and the dates _____

Have you had acupuncture before? Yes ☐ No ☐ If Yes, when and for what condition?

What is the main reason for your visit?

How long has this problem been bothering you?

Have you been treated for this condition before? Yes ☐ No ☐ If Yes, when and by what means of treatment?

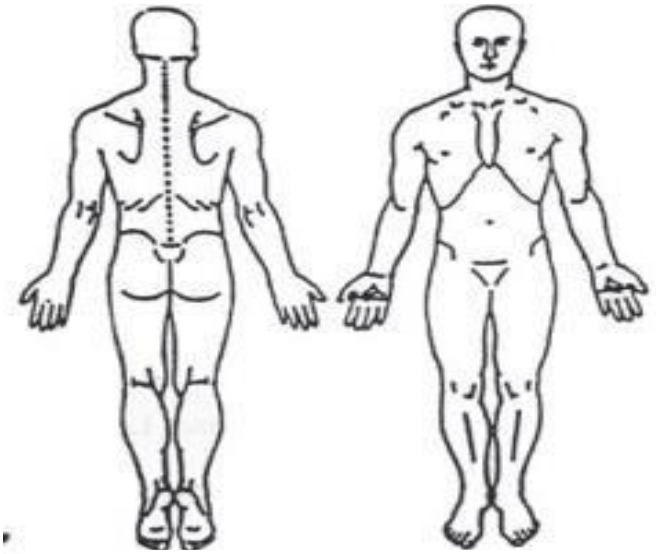
List any secondary conditions you would like to be treated for.

Is there a family history of:

☐ Cancer
☐ TB
☐ Diabetes
☐ Arthritis
☐ Mental Illness
☐ Asthma
☐ Other, please list

☐ Allergies
☐ Anemia
☐ High Blood Pressure
☐ Low Blood Pressure
☐ Heart Trouble
☐ Hepatitis

Please mark areas of pain on diagrams



Back **Front**

Are you now suffering from any of the following?

- ☐ Frequent urination
- ☐ Painful urination
- ☐ Night-time urination
- ☐ Dark color urine
- ☐ Night sweats
- ☐ Impaired hearing
- ☐ Ringing in ears
- ☐ Hair loss or thinning

- ☐ Constipation
- ☐ Diarrhea
- ☐ Hemorrhoids
- ☐ Bloody stool
- ☐ Indigestion
- ☐ Abdominal pain
- ☐ Lower bowel gas
- ☐ Heartburn
- ☐ Belching
- ☐ Abdominal bloating
- ☐ Nausea
- ☐ Vomiting
- ☐ Sores on tongue
- ☐ Sores in mouth cavity
- ☐ Hiccups
- ☐ Bleeding gums
- ☐ Difficulty swallowing
- ☐ Increased appetite
- ☐ Loss of appetite

- ☐ Shortness of breath
- ☐ Irregular heartbeat
- ☐ Palpitations
- ☐ Fainting
- ☐ Chest pain
- ☐ Leg cramps
- ☐ High blood pressure
- ☐ Anemia
- ☐ Frequent colds
- ☐ Ankle swelling
- ☐ Easily chilled
- ☐ Sweat upon easy exertion
- ☐ Easily fatigued
- ☐ Dry cough
- ☐ Cough with phlegm
- ☐ Sore throat
- ☐ Hay fever
- ☐ Sinusitis
- ☐ Asthma

- ☐ Acne
- ☐ Dry skin
- ☐ Itching
- ☐ Rashes or eczema
- ☐ Psoriasis
- ☐ Bruise easily

- ☐ Insomnia
- ☐ Depression
- ☐ Worry
- ☐ Anxiety
- ☐ Irritability
- ☐ Feelings of fear
- ☐ Sadness
- ☐ Grief
- ☐ Anger
- ☐ Nervousness
- ☐ Poor concentration
- ☐ Forgetfulness
- ☐ Morning fatigue
- ☐ Afternoon fatigue

- ☐ Headaches
- ☐ Migraine
- ☐ Dizziness
- ☐ Blurred vision
- ☐ Dry eyes
- ☐ Brittle nails
- ☐ Bitter taste in mouth
- ☐ Pain under ribs
- ☐ Lymph node enlargement

- ☐ Arthritis
- ☐ Muscle spasm
- ☐ Bursitis
- ☐ Stiff or painful neck
- ☐ Upper back pain
- ☐ Mid back pain
- ☐ Lower back pain

Painful joints: (indicate below)

- ☐ Hip
- ☐ Knee
- ☐ Ankle
- ☐ Shoulder
- ☐ Elbow
- ☐ Wrist

- ☐ Sciatica
- ☐ Weak limbs
- ☐ Numbness/tingling in limbs
- ☐ Loss of grip
- ☐ Hand or finger pain
- ☐ Foot pain
- ☐ Poor circulation

Height _____

Weight _____

Body Temperature:

- ☐ Comfortable
- ☐ Often feel hot
- ☐ Often feel cold

Do you:

- ☐ Exercise regularly
- ☐ Get enough sleep
- ☐ Eat regular meals
- ☐ Prefer cold drinks
- ☐ Prefer hot drinks
- ☐ Smoke cigarettes
- ☐ Have a stressful job

Women, have you ever had:

- ☐ A pregnancy
- ☐ An abortion
- ☐ Yeast or vaginitis
- ☐ Uterine cysts or tumors
- ☐ Ovarian cysts
- ☐ Mastitis
- ☐ Irregular menses
- ☐ Cramps
- ☐ Clots or dark menses
- ☐ Heavy bleeding
- ☐ Light scanty bleeding
- ☐ Water retention
- ☐ Mood changes
- ☐ Painful breasts
- ☐ Low or no sex drive
- ☐ Hot flashes
- ☐ Missed periods

Women complete the following:

Age menstrual cycle started _____

Age stopped _____

Intervals between periods _____

Duration of period

Quantity of flow _____

Date of last period _____

Date of last PAP test _____

Men, do you have:

- ☐ Low or no sex drive
- ☐ Impotence
- ☐ Urethra discharge
- ☐ Prostate trouble