Windstone Acupuncture LLC
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Patient Registration and Questionnaire

ALL INFORMATION IS CONFIDENTIAL

Today's Date: ____

Name: ____

Street Address: ____

City, State, Zip: ____

Phone: ________________ Email address:__________________________

Add to the emailing list? (you can unsubscribe at any time) ________Yes ___No

Date of Birth: ______________________ Current Age: ________________

Occupation: ____

Emergency Contact: ____________________ Phone: __________________

Physician: ________________________Date of last checkup: ____________

Whom may I thank for referring you? ________________________________

Have you ever had acupuncture before? ______________________________

What is the main reason you are seeking treatment?

1. ____
2. ____
3. ____

Please give a brief history of chief complaint and how it started:

____

____

____

How long has it persisted? ___________ ☐days ☐weeks ☐months ☐years
Have you had a similar condition before? _______________________

Recently the condition is ☐improved ☐worsened
Comments:____

Is there anything that makes it better: ____

Is there anything that makes it worse: ____

Have you previously been treated for this condition? ☐ yes ☐ no

If so: When? By whom? ____

What was the diagnosis? ____

What type of treatment? ____

What were the results of treatment? ____

Are you taking any of the following? ☐pain killers ☐blood thinners ☐anti-depressants

Please list any medication/herb/supplement you are currently taking:

Name	Dosage	Reason	How often	Taking since

Please list any major hospitalizations, injuries, or accidents you have had with approximate dates (if listing births please be sure to indicate type of delivery):

Date	Description

Please check any conditions you currently have or have had in the past:

□Allergies	□Cancer	□High/Low blood pressure	□MS
□Anemia	□Depression	□HIV/AIDS	□Neurological Disorder
□Anxiety	□Diabetes	□IBS	□Spinal Injury
□Arthritis	□Epilepsy	□Infertility	□Stroke
□AutoImmune	□Heart Disease	□Kidney Disease	□Thyroid Disorder
□Bleeding Disorder	□Hepatitis	□Liver Disease	□Ulcers

Current Symptom Profile
Please check all that apply.

Habits:
□cigarettes □sodapop
□salt
□coffee
□alcohol □sweets
□recreational drugs
□stress □artificial sweetners

Appetite:
□up and down □low
□excessive □good
□loss of taste

Cravings:
□sweet □spicy □salty
□sour □bitter □none

Weight: □normal
□underweight
□overweight
□recent weight loss
□recent weight gain

Energy:
□up and down □low
□excessive □normal
□low after eating
□tired in the afternoon

Digestion:
□indigestion □bloating
□heartburn □nausea
□vomiting □full feeling
□belch or burping □gas
□abdominal pain or cramping □normal
□difficulty digesting fatty or oily foods
□bitter taste in mouth
□gall stones

Bowels:
Freq: ______per day/week
□loose stool □diarrhea
□hemorrhoids
□constipation
□colon problems
□pain or cramping
□take laxaties
□normal

Urination:
freq: ______ x/ day
Color:
□clear □pale yellow
□yellow □dark yellow
□dark
Symptoms:
□burning □freq infections
□urgency □freq nighttime
□incontinence
□kidney stone □none

Thirst:
□normal □excessive
□thirsy but do not drink
How Much water per day?
____
I prefer my drinks:
□hot/warm □cold
□room temperature

Exercise:
□never □little
□moderate □heavy

Body temp:
□runs warm □flushed face
□runs cold □normal
□cold extremities
□sweats easily
□sweats at night

Sleep:
Falling asleep:
□easy □average □difficult
Staying asleep:
□easy □average □difficult
Waking up:
□easy □average □difficult
Sleep Quality:
□restless □lots of dreams
□easily awakened
□nightmares
□difficulty falling back asleep
Bedtime_________
Wake Time________
# of times you wake in the middle of the night _____

Headache/Dizziness:
□headaches
□migraines
□vertigo □dizziness
□motion sickness
□poor balance
□fainting
□poor memory
□none

Eyes:
□dry eyes
□swollen eyes
□itchy □twitchy
□light sensitive
□tear easily
□normal

Ears:
□poor hearing
□high pitch ringing
□low pitch hearing
□earaches
□normal

Nose:
□stuffy nose □hayfever
□frequent sneezing
□bleeding
□loss of smell
□sinusitis
□rhinitis
□normal

Mouth and Throat:
□dry □gum problems
□frequent colds □TMJ
□feel lump in throat
□thyroid problems
□grind teeth
□normal

Skin:
□dry □hives □itching
□oily □acne □rashes
□bruise easily
□eczema
□cuts heal slowly
□normal

Hair:
□dry □oily □dandruff
□falling out □early grey
□normal

Nails:
□soft □spots □ridges/lines
□grow slowly
□grow fast
□purple
□pale
□break easily
□normal

Cardiovascular:
□diagnosed heart problems
□palpitations □murmur
□bleeds easily
□low blood pressure
□high blood pressure
□high cholesterol
□varicose veins
□ankle swelling
□chest pain □bruise easily
□hand swelling
□irregular heart beat
□normal

Emotional:
I would generally describe myself as:
(check all that apply)
□happy □easy going
□restless □irritable
□indecisive □angry
□cry easily □in a hurry
□depressed □stressed out
□difficulty expressing emotion
□short attention span

Respiratory:
□shortness of breath
□difficulty inhaling
□sigh a lot □dry cough
□cough with phlegm
□asthma □bronchitis
□emphysema □wheezing
□cough with blood
□tightness in chest
□normal

Pain:
□neck
□back
□shoulder
□sciatica
□hands
□wrists
□cramps
□hips
□knees
□cold or damp weather
□foot/ankle
□spine
□flank
□arthritis
□none

Have you ever had Lyme disease or any other infectious disease: ____ Yes _____No

If so which? ____

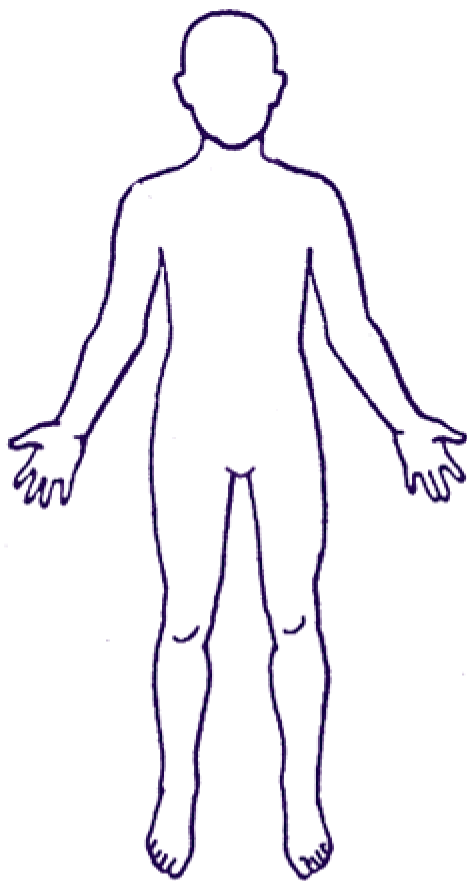
Please list all known food, drug, or environmental allergies:

____

____

____

If you have pain, please indicate where:



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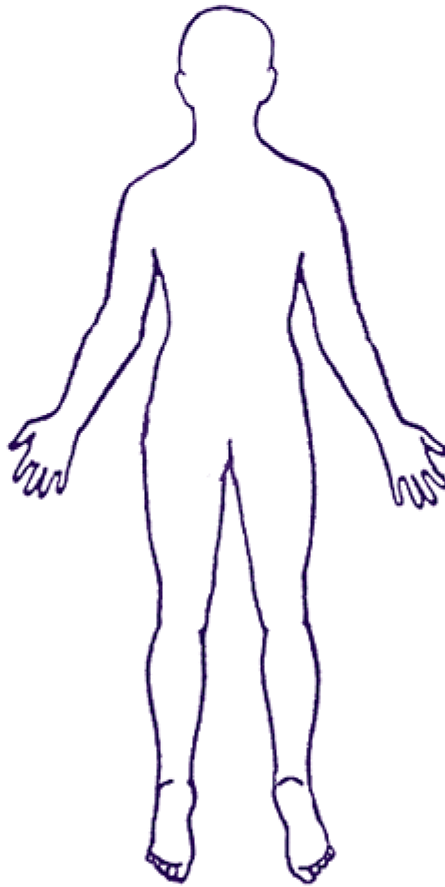

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