DuRoss Acupuncture
& Herbal Medicine

# NEW ACUPUNCTURE PATIENT QUESTIONAIRE

## Personal Information

First Name: _____ Last Name: _____

Address/City/Zip: _____

Work Phone: _____ Home Phone: _____

DOB: _____ Age: _____ Weight: _____ Height: _____

Sex: F / M Relationship Status: S / M / D / Other Number of Children: _____

Occupation: _____ Employer: _____

Email: _____ Referred By: _____

**Information provided will remain confidential between you and the practitioner.**
***Please complete as accurately as possible***

What is your current chief complaint? _____

_____

When did the condition begin? _____

_____

How did it begin? _____

_____

Have you received treatment for this condition?
List any healers or therapies with which you are involved:

_____

_____

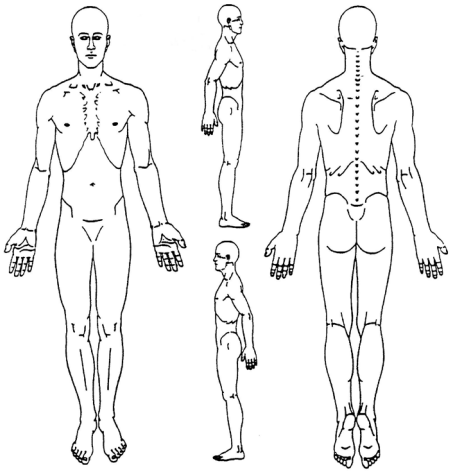
Other concerns and/or health goals: _____

_____

_____

_____

***Please mark on the chart any where you feel pain***



The most important thing I can do to improve my health is? _____

_____

_____

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**Medical History**

Please list other serious hospitalizations, injuries, illnesses or surgeries you have had.
When did you have them?: _____

_____

_____

Please list and explain all allergies or sensitivities: _____

_____

_____

**Is there a family history of? (Circle all that apply):**

| | | |
|---|---|---|
| Heart Disease | High Blood Pressure | Stroke |
| Cancer | Diabetes | Bleeding Disorders |
| Drug or Alcohol Abuse | Alzheimers | Mental Health Disorders |

**Do you crave sugar, coffee, cigarettes, or have any major addictions? If so, please explain:**

_____

_____

History of Smoking: Y / N How Many Per Day: _____ For How Long: _____

Number of Drinks per Week: _____ Recreational Drug Use: Y / N

**Physical Fitness & Nutrition**

Do you exercise regularly: Y / N Type of Exercise: _____

How Often: _____ Duration: _____

List Special Dietary Restrictions: _____

_____

_____

Do you take any supplements and/or herbs? If so, please list: _____

_____

_____

What is your diet like these days, please explain: _____

_____

_____

Do you cook?: _____

_____

Will your friends and family be supportive of your desire to make food and/or lifestyle changes?:

_____

_____

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**Sleeping Habits**

How is your sleep?: _____

How many hours of sleep on average do you get each night?: _____

What time do you go to bed?: _____

What time do you wake up?: _____

Do you wake during the night? If so, why?: _____

**Women's Health History**

Age of your first menstrual cycle: _____ Are your periods regular?: Y / N

How many days is your flow?: _____ How frequent?: _____

How heavy?: _____ Are there clots?: _____

Do you have vaginal discharge?: _____

Do you suffer from PMS symptoms? If so, please explain: _____

Have you reached or are you approaching menopause?: Y / N

Do you use birth control?: Y / N

Additional comments: _____

Any thing else you would like to share?: _____

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Please list the medicine name dosage and frequency for all medications, supplements and herbs you currently use:

| Medication/Supplement/Herb | Dosage | Frequency |
|---|---|---|
| 1. | | |
| 2. | | |
| 3. | | |
| 4. | | |
| 5. | | |
| 6. | | |
| 7. | | |
| 8. | | |
| 9. | | |
| 10. | | |
| 11. | | |
| 12. | | |
| 13. | | |
| 14. | | |
| 15. | | |

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*CHECK ALL CURRENT AND PAST CONDITIONS*

*(Please write the word PAST next to those conditions which you have had **only** in the past and are no longer present)*

HEAD AND NECK:
_____ Dizziness
_____ Fainting
_____ Neck Stiffness
_____ Enlarged lymph glands
_____ Headaches
_____ Other

EARS:
_____ Infection
_____ Ringing
_____ Decreased hearing
_____ Other

EYES:
_____ Blurred vision
_____ Visual changes
_____ Poor night vision
_____ Spots/Floaters
_____ Eye inflammation/Styes
_____ Other

NOSE, THROAT & MOUTH:
_____ Bleeding
_____ Sinus infection
_____ Hay fever or allergies
_____ Sore throat
_____ Hoarseness
_____ Changes in taste
_____ Difficulty swallowing
_____ Changes in smell
_____ Oral ulcers/Canker sores
_____ Other

SKIN:
_____ Hives
_____ Rashes
_____ Eczema
_____ Psoriasis
_____ Seborrhea
_____ Night sweating
_____ Excess sweating
_____ Dryness
_____ Bruises easily
_____ Changes in moles or lumps
_____ Other

NEUROLOGICAL:
_____ Numbness or tingling of limbs
_____ Seizures
_____ Tremors
_____ Pain
_____ Paralysis
_____ Epilepsy or Convulsions
_____ Other

INFECTION HISTORY:
_____ HIV/AIDS, or HIV risks: Self or partner
_____ TB: Self or household
_____ Hepatitis, or Hepatitis risk: Self or partner.
_____ History of sexually transmitted diseases: self or partner.
_____ Gonorrhea
_____ Chlamydia
_____ Syphilis
_____ Genital warts
_____ Herpes (oral)
_____ Herpes (genital)
_____ MRSA, Staph, CRE, or other Drug-Resistant Infections

RESPIRATORY:
_____ Chronic cough
_____ Coughing up blood
_____ Coughing phlegm frequently
_____ Difficulty breathing
_____ Wheezing/Asthma
_____ Frequent Colds
_____ Emphysema
_____ Pneumonia repeatedly
_____ Other

CARDIOVASCULAR:
_____ Palpitations
_____ Chest pain or tightness
_____ Rapid heartbeat
_____ Irregular heart beat
_____ Heart Disease
_____ Poor circulation
_____ Swelling of ankles
_____ Phlebitis
_____ Cold hands/feet
_____ Cardiac Pacemaker
_____ High blood pressure
_____ Stroke
_____ Other

GASTROINTESTINAL:
_____ Indigestion
_____ Nausea
_____ Stomach pain
_____ Irritable bowel disease
_____ Colitis
_____ Crohn's Disease
_____ Pancreatitis
_____ Celiac Disease
_____ Recent change in bowel habits
_____ Diarrhea ( _____ /day)
_____ Constipation ( _____ /week)
_____ Dry, hard stools
_____ Soft, difficult, sticky stools
_____ Irregularly or poorly-formed stools
_____ Poor appetite
_____ Excessive hunger
_____ Blood in stool or black stools
_____ Hemorrhoids
_____ --with pain or blood
_____ Gall bladder disorder
_____ Vomiting blood
_____ Peptic Ulcer
_____ Recent change in weight
_____ Food cravings
_____ Other

MUSCLES AND JOINTS:
_____ Joint disorder
_____ Sore muscles
_____ Weak muscles
_____ Difficulty walking
_____ Spinal curvature
_____ Backache
_____ Back pain
_____ Fibromyalgia
_____ Other

MALE:
_____ Pain/itching of genitalia
_____ Genital lesions/discharge
_____ Impotence
_____ Premature ejaculation
_____ Prostate problems
_____ Infertility (e.g., abnormal sperm)
_____ Other

FEMALE:
_____ Frequent vaginal infections
_____ Infertility
_____ Pain/itching of genitalia
_____ Genital lesions/discharge
_____ Pelvic inflammatory disease
_____ Abnormal Pap smear
_____ Irregular periods
_____ Emotional changes with menses
_____ Clots with menses
_____ Painful menstrual periods/cramps
_____ Premenstrual Syndrome
_____ Abnormal bleeding
_____ Menopausal symptoms (hot flashes, etc.)
_____ Breast lumps/cysts
_____ Breast swelling and/or pain
_____ Other

URINARY:
_____ Frequent urinary tract/bladder infections
_____ Weak urinary stream
_____ Recent change in bladder habits
_____ Kidney Disease
_____ Frequent day urination (_____ X)
_____ Frequent night urination (_____ X)
_____ Other

GENERAL:
_____ Fatigue
_____ Thirst
_____ Aversion to cold
_____ Insomnia
_____ Frequent dreams/nightmares
_____ Depression
_____ Agitation
_____ Irritability
_____ Anxiety
_____ History of psychiatric treatment
_____ Poor memory
_____ Difficulty concentrating
_____ Sores that don't heal
_____ Congenital abnormalities
_____ Surgical implants
_____ Unusual bleeding or discharge
_____ Jaundice
_____ Hernia
_____ Epstein Barr virus (EBV)
_____ Rheumatic Fever
_____ Diabetes mellitus
_____ Thyroid Disorder
_____ Cancer
_____ Anemia or other blood disorder
_____ Lupus erythematosis
_____ Other

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# FEE SCHEDULE AND CANCELLATION POLICY

Occasionally we may go over our allotted time in a session. We will only charge you for the time period you are scheduled.

**Standard Fees**
New client session with acupuncture ( 1.5 hours) $130.00
Additional sessions (45 min – 1 hour) $90.00

***Fees are due at time of service

**Cancellations**
I understand that situations occur and you can not always make your appointment. If you anticipate missing your scheduled appointment, please let me know as soon as possible. I ask for a minimum notice of 24 hours in advance. You may be charged for a missed appointment or cancellation if less than 24 hours notice is given.

I will make every effort to be on time for your scheduled appointment. In the unlikely case I am unable to make your appointment, I will make every effort to give you as much advanced notice as possible.

If you have any questions regarding this policy please call or text 586.491.8507
or reach me by email at durossacupuncture@gmail.com.

Thanks for your consideration!

Denise DuRoss, L.Ac

Patient Name: _____ Signature: _____ Date: _____

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