# Acupuncture Questionnaire

Simple Therapeutics
Fitness & Wellness Center

Client: _____

Date: _____

**Health History**

Please indicate conditions that you have or have had in the past year.

## Pain, Numbness, or Weakness in:

Current ☐ Past ☐ Hands/Wrists
Current ☐ Past ☐ Arms
Current ☐ Past ☐ Shoulders
Current ☐ Past ☐ Neck
Current ☐ Past ☐ Back
Current ☐ Past ☐ Legs
Current ☐ Past ☐ Other _____
Current ☐ Past ☐ Hips
Current ☐ Past ☐ Knees
Current ☐ Past ☐ Feet/Ankles
Current ☐ Past ☐ Jaw/TMJ

## Muscles/Joints/Tendons/Bones:

Current ☐ Past ☐ Swollen Joints
Current ☐ Past ☐ Cramps or Spasms
Current ☐ Past ☐ Tremors
Type of Pain:_____
(burning, aching, sharp,stabbing, etc)

## Eyes/Ears/Nose/Throat:

Current ☐ Past ☐ Blurred/Failing vision
Current ☐ Past ☐ Red Eyes
Current ☐ Past ☐ Itchy/Dry eyes
Current ☐ Past ☐ Spots in front of eyes
Current ☐ Past ☐ Ringing in ears
Current ☐ Past ☐ Earache
Current ☐ Past ☐ Loss of hearing
Current ☐ Past ☐ Sinus congestion
Current ☐ Past ☐ Nosebleeds
Current ☐ Past ☐ Hay fever/allergies
Current ☐ Past ☐ Frequent colds
Current ☐ Past ☐ Sore throat
Current ☐ Past ☐ Cough
Current ☐ Past ☐ Phlegm Color:_____
Current ☐ Past ☐ Hoarseness
Current ☐ Past ☐ Dry mouth/throat
Current ☐ Past ☐ Mouth sores/Canker sores

## Temperature:

Current ☐ Past ☐ Cold hands or feet
Current ☐ Past ☐ Chills
Current ☐ Past ☐ Hot flashes
Current ☐ Past ☐ Fever or heat sensations
Current ☐ Past ☐ Sweating

## Cardiovascular:

Current ☐ Past ☐ Angina
Current ☐ Past ☐ Chest pain
Current ☐ Past ☐ Arteriosclerosis
Current ☐ Past ☐ Heart attack
Current ☐ Past ☐ MI
Current ☐ Past ☐ High blood pressure
Current ☐ Past ☐ Low blood pressure
Current ☐ Past ☐ High cholesterol
Current ☐ Past ☐ Irregular heartbeat
Current ☐ Past ☐ Rapid heartbeat
Current ☐ Past ☐ Palpitations
Current ☐ Past ☐ Poor circulation
Current ☐ Past ☐ Swollen ankles
Current ☐ Past ☐ Congestive heart failure

## Emotional symptoms:

Current ☐ Past ☐ Anger/Irritability
Current ☐ Past ☐ Anxiety/Nervousness
Current ☐ Past ☐ Depression
Current ☐ Past ☐ Easily startled
Current ☐ Past ☐ Indecisive
Current ☐ Past ☐ Excessive fear
Current ☐ Past ☐ Excessive grief
Current ☐ Past ☐ Excessive worry
Current ☐ Past ☐ Forgetfulness
Current ☐ Past ☐ Difficulty focusing
Current ☐ Past ☐ Mania/hypomania
Current ☐ Past ☐ Suicidal thoughts

## General:

Current ☐ Past ☐ Insomnia
Current ☐ Past ☐ Poor sleep
Current ☐ Past ☐ Awaken early
Current ☐ Past ☐ Headaches/Migraines
Current ☐ Past ☐ Dizziness/Vertigo
Current ☐ Past ☐ Fatigue/Tiredness
Current ☐ Past ☐ Excessive thirst

## Skin:

Current ☐ Past ☐ Acne
Current ☐ Past ☐ Boils
Current ☐ Past ☐ Cysts
Current ☐ Past ☐ Bruise easily
Current ☐ Past ☐ Dry skin
Current ☐ Past ☐ Hair and/or nail problems
Current ☐ Past ☐ Itching
Current ☐ Past ☐ Rash
Current ☐ Past ☐ Hives
Current ☐ Past ☐ Eczema
Current ☐ Past ☐ Night sweating
Current ☐ Past ☐ Day sweating

## Genito/Urinary:

Current ☐ Past ☐ Blood/pus in urine
Current ☐ Past ☐ Frequent urination
Amount: Scant ☐ Profuse ☐
Current ☐ Past ☐ Incontinence/Unable to control urine
Current ☐ Past ☐ Kidney infection/stones
Current ☐ Past ☐ Low libido
Current ☐ Past ☐ Other
_____

## Gastrointestinal:

Current ☐ Past ☐ Belching
Current ☐ Past ☐ Bloating
Current ☐ Past ☐ Gas
Current ☐ Past ☐ Colitis
Current ☐ Past ☐ Colon problems
Current ☐ Past ☐ IBS
Current ☐ Past ☐ Constipation
Current ☐ Past ☐ Diarrhea
Current ☐ Past ☐ Bloody stools
Current ☐ Past ☐ Difficulty swallowing
Current ☐ Past ☐ Distention of abdomen
Current ☐ Past ☐ Excessive hunger
Current ☐ Past ☐ Gall bladder problems
Current ☐ Past ☐ Hemorrhoids
Current ☐ Past ☐ Indigestion
Current ☐ Past ☐ GERD
Current ☐ Past ☐ Acid reflux
Current ☐ Past ☐ Nausea
Current ☐ Past ☐ Pain in stomach area
Current ☐ Past ☐ Poor appetite
Current ☐ Past ☐ Vomiting
Current ☐ Past ☐ Other
_____

## For Men Only:

Current ☐ Past ☐ ED/Impotence
Current ☐ Past ☐ Hernia/Groin pain
Current ☐ Past ☐ Penis discharge
Current ☐ Past ☐ Premature ejaculation
Current ☐ Past ☐ Prostate problems

## For Women Only:

Age of first menses:_____
Days between menses:_____
Number of pregnancies:_____
Current ☐ Past ☐ Miscarriages: #_____
Current ☐ Past ☐ Clots in menses
Current ☐ Past ☐ Bleeding between periods
Current ☐ Past ☐ Irregular cycles
Current ☐ Past ☐ Menopausal symptoms
Current ☐ Past ☐ PMS
Current ☐ Past ☐ Light periods
Current ☐ Past ☐ Heavy periods
Current ☐ Past ☐ Painful periods
Current ☐ Past ☐ Spotting/scanty flow
Current ☐ Past ☐ Yeast infections
Current ☐ Past ☐ Other
_____