

# FIVE ROADS ACUPUNCTURE

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## Initial Questions Form

Date:

Please answer as thoroughly as possible. This is detailed so that I can better understand what is going on with you as a whole person. This information will be uploaded into a HIPAA compliant document, and then destroyed.

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### General Patient Information

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Name:

DOB:

Height:

Weight:

What are your reasons for seeking acupuncture treatment and how long have you had this/these issue(s)?

Please list all major injuries, hospitalizations, accidents, and surgeries including the year they happened.

Are you a carrier of any blood borne pathogens?

HIV

Hepatitis B

Hepatitis C

Other (please explain):

Do you have a pacemaker?

Yes

No

Please list all current medications and dosage, including vitamins, herbs and supplements:

Please list all allergies (outdoor, food, animals, etc.):

What major health conditions are in your immediate family?

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### Lifestyle and Habits

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Tobacco Use:

Never Used

Former User

Current User

If current user, please list quantity, and frequency:

Alcohol Use Per Week:

Cannabis Use:

None

Sometimes/Social

Moderate Use

Daily Use

Exercise Habits (frequency and type):

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### Food and Digestion

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Are there foods you avoid? Why?

What is your typical Breakfast, Lunch and Dinner?

Do you experience any of the following after meals?

	Never	Rarely	Sometimes	Often	Always
Heartburn	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bloating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cramping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gas	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Burps	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Food just "sits"	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nausea/vomiting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Is your appetite:

Low

Average

Excessive

What flavors do you *crave*?

Sweet

Salty

Spicy

Sour

What flavors do you *avoid*?

Sweet

Salty

Spicy

Sour

Is your thirst:

Below Average

Average

Above Average

Beverage preference:

Warm

Room Temperature

Cold/Iced

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## Elimination

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How many bowel movements per day?

Which of the following do you experience?

	Never	Rarely	Sometimes	Often	Always
Hard Stools	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Loose Stools	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Small Round Stools	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dry and Hard to Pass	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thin Stools	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding with Stools	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Black Tarry Stools	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Yellow or Clay Colored Stools	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Abdominal Discomfort with Passing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hemorrhoids	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stronger than Normal Smelling Stools	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Do you experience any issues with urination?

	Never	Rarely	Sometimes	Often	Always
Urgency	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

	Never	Rarely	Sometimes	Often	Always
Frequency	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dribbling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Incontinence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Trouble Emptying	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Completely					
Darker than Normal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Strong Smelling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Prone to UTI's	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bladder/Kidney Stones	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Going more than once in a night	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cloudiness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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### Energy and Sleep

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What time of day is your energy the lowest?

What time of day is your energy the highest?

Do you fall asleep easily?

Yes                       No                       Rarely                       Sometimes

Do you stay asleep all night?

Yes                       No                       Rarely                       Sometimes

Do you feel refreshed upon waking?

Yes                       No                       Rarely                       Sometimes

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### Head, Neck and Throat

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How frequently do you experience headaches?

Daily                       Weekly                       Monthly                       Rarely                       With Triggers( with  
menstruation or allergies;  
please elaborate below)

Other, please explain:

What are your headache triggers, if any?

Check all that apply to how your headache pain feels:

- Dull       Sharp       Heavy       Electric       Auras       Nausea/  
Vomiting

Where is the pain located?

- Base of Skull       Temples       Top of Head       Fore-head       Sinuses       Behind Eyes       Inside the Head

Do you ever experience dizziness?

- Never       Rarely       Sometimes       Often

Eye Symptoms – Check all that apply:

- Redness       Itchiness       Dryness       Blurriness  
 Floaters       Pain       Near-Sighted       Far-Sighted

Ear Symptoms – Check all that apply:

- High Pitched Ringing       Low Pitched Ringing       Discharge       Excessive Wax  
 Hearing Loss

Nose Symptoms – Check all that apply:

- Chronic Nasal Discharge       Clear Mucous       White Mucous       Yellow Mucous  
 Green Mucous       Recurring Sinus Infections       Polyps       Frequent Nosebleeds

Throat Symptoms – Check all that apply:

- Dry Throat       Itchy Throat       Hoarseness       Feeling of a lump in the throat  
 Swollen and Red Throat       Hypothyroid       Hyperthyroid       Goiter/Nodules

Mouth and Teeth Symptoms – Check all that apply:

- Cold Sores       Tongue Sores       Bleeding Gums       Sensitive Teeth  
 Missing Teeth       Prone to Cavities       Trouble Swallowing

## Body Pain

Do you currently, or have you had pain in the following locations?

	Always	Sometimes	In the Past	Never
Neck	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Shoulders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Upper-Back	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mid-Back	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lower-Back	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Elbows	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Wrists	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fingers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hips	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Groin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Knees	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Calves	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ankles	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Feet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Toes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Arch of Foot	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Is the pain in the:

Muscles

Tendons

Joints

When, and how did the pain start?

What is the quality of the pain?

Dull and Spread Out

Sharp, Localized,  
and Stabbing

Shooting and  
Electric

Burning Sensation

Tight and Pulling

Numbness and  
Tingling

Cramps and Spasms

Swelling

What helps/makes the pain worse?

Hands on Pressure/Massage

Chiropractic

Other Body Work

Application of Heat

Application of Ice

Rest

Movement

Makes Pain Better








Makes Pain Worse

Metabolism:

Low

Average

High

Sweat:

Normal  
Sweating Upon  
Exertion

Heavy  
Sweating

Unusually Bad  
Odor

Night Sweats

Little Sweating  
Even Upon  
Exertion

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### Chest and Abdomen

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Chest issues:

Feeling Heart Flutter

Pain in the Chest

A Feeling of  
Oppression in the  
Chest

Heart Murmur

Other Congenital  
Heart Issue

Coronary Heart  
Disease

Blood Clotting  
Disorder \*

Congestive Heart  
Failure

Poor Circulation

Cold Hands

Cold Feet

Other (please  
explain)

\*If blood clotting disorder, stop and contact us!

Respiratory issues:

Recurrent upper  
respiratory infections

Recurring sinus  
infections

Chronic nasal  
congestion

Chronic cough

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### Mental, Emotional and Social

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Negative emotional patterns:

	Currently	In the Past
Depression	<input type="checkbox"/>	<input type="checkbox"/>
Anxiety	<input type="checkbox"/>	<input type="checkbox"/>
Sadness/Grief	<input type="checkbox"/>	<input type="checkbox"/>
Apathy	<input type="checkbox"/>	<input type="checkbox"/>
Worry	<input type="checkbox"/>	<input type="checkbox"/>
History of Childhood Abuse	<input type="checkbox"/>	<input type="checkbox"/>
Domestic Violence	<input type="checkbox"/>	<input type="checkbox"/>

Are you currently under the care of a mental health care professional? If yes, please explain.

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## Sexual Health

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Check all that apply:

Low Sex Drive

Sexual Arousal, but  
Orgasm is Difficult

Higher Than  
Average Sex Drive

Sexually  
Transmitted Diseases

### MEN only

Any history of the following issues?

<input type="checkbox"/> Soft Erection	<input type="checkbox"/> Can't Achieve Erection	<input type="checkbox"/> Nocturnal Emissions
<input type="checkbox"/> Prostate Issues	<input type="checkbox"/> Infertility	

### WOMEN only

What was the start date of your last period? \_\_\_/\_\_\_/\_\_\_

What age was your first menstrual cycle?

Is your cycle currently influenced by birth control?

<input type="checkbox"/> Yes	<input type="checkbox"/> No
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What are you currently using for birth control?

How many days are in your entire cycle? 28 days? Shorter? Longer? Irregular?

How many days of bleeding?

Color and consistency of menstrual blood:

	Beginning of Bleeding	Middle	End
Dark Red Blood	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Light Watery Blood	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Brown Blood	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



	Beginning of Bleeding	Middle	End
Mucous in Blood	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tiny Bead Like Blood Clots	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dime Sized Clots	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Quarter Size Clots	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mild Cramps	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Moderate Cramps	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Severe Cramps	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heavy Bleeding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Change in Stools	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Food Cravings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Irritable	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sensitive Emotionally	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bloating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

At your period's heaviest, how many times per day are you changing your pad/tampon/menstrual cup?

Other gynecological issues:

- Benign Breast Lumps     
 Breast Cancer     
 Cervix/Ovarian Cancer     
 Endometriosis  
 Polycystic Ovaries     
 Trouble Getting Pregnant

Total number of pregnancies:

Number of pregnancy terminations:

Number of miscarriages:

Number of pregnancy losses:

Number of live births:

Are you, or could you be pregnant now?

- Yes     
 No

Any problems with pregnancy?

Any issues with your birth(s)?

Any issues postpartum?

Any issues with nursing?