Theresa Palazzo L.Ac.

First Visit Questionnaire for Women

Please note: This questionnaire will be kept confidential. Your answers will help to determine the best treatment plan for you. If you have any questions, please ask.

General Information Today's Date:

Name		
Street Address		
City	State	Zip

Phone Number where I may contact you: _____

Email where I may contact you: _____

Emergency Contact: Name_____ Phone_____

Sex: Male/Female/Transexual Height: Weight:

Date of Birth: Age:

Marital Status: Do you have children? Yes / No How many?_____

Occupation:

Have you received acupuncture before? Yes / No Chinese Herbal Medicine? Yes / No

Who referred you to me?_____

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Current Health History

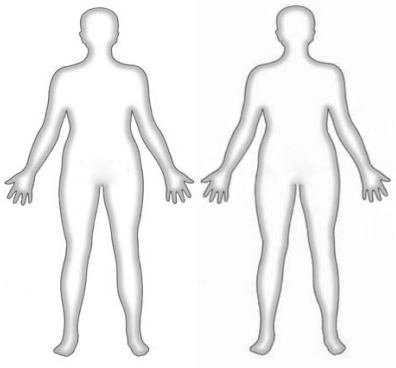
Please list, in order of priority, your reasons for seeking acupuncture treatment, and how long you have had each condition.

	Condition	How Long
1.	_____	#_____Months/Years
2.	_____	#_____Months/Years
3.	_____	#_____Months/Years
4.	_____	#_____Months/Years
5.	_____	#_____Months/Years

What other forms of treatment have you tried for these conditions?

Please mark these figures to show the location of any body pain you have:

FRONT BACK



Are you presently under the care of a physician? Yes/No

If yes, for what condition? _____ For how long? _____

Current Medications

List any prescribed medications you are currently taking (over-the-counter/supplements should be listed on the back).

Medicine	Dosage	Start Date	Prescribed By	Reason

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Symptom Survey

Check any of the following symptoms you have currently, or have had in the past.

Symptom	Now	Past	Symptom	Now	Past	Symptom	Now	Past
Lack of appetite	☐	☐	Difficulty focusing / making plans or decisions	☐	☐	Cough	☐	☐
Excessive appetite	☐	☐	Muscle Spasms/Cramps	☐	☐	Shortness of Breath	☐	☐
Loose stool/diarrhea	☐	☐	Insomnia	☐	☐	Asthma	☐	☐
Indigestion	☐	☐	Difficulty Falling Asleep	☐	☐	Tend to Catch Colds Easily	☐	☐
Vomiting	☐	☐	Difficulty Staying Asleep	☐	☐	Allergies	☐	☐
Nausea	☐	☐	Heart Palpitations	☐	☐	Low sense of smell	☐	☐
Belching	☐	☐	Irregular Heart Beat	☐	☐	Nasal Problems	☐	☐
Bad Breath	☐	☐	Nightmares	☐	☐	Skin Issues	☐	☐
Heartburn/Reflux	☐	☐	Mentally Restless	☐	☐	Bronchitis	☐	☐
Feeling the retention of food	☐	☐	Laughing for no reason	☐	☐	Colitis/Diverticulitis	☐	☐
Ulcers	☐	☐	Angina Pains	☐	☐	Constipation	☐	☐
Easy to Bruise	☐	☐	Dark/scanty urination	☐	☐	Feeling of Excessive Fear	☐	☐
Hemorrhoids	☐	☐	Abdominal Pain	☐	☐	Low Back Pain	☐	☐
Tendency to feel obsessive in work/relationships	☐	☐	Chest Pain	☐	☐	Knee Pain	☐	☐
Feeling Excessive Worry	☐	☐	Sciatic Pain	☐	☐	Hearing Impairment	☐	☐
Frequent use of antibiotics	☐	☐	Ribside Pain	☐	☐	Ear Ringing	☐	☐
High Cholesterol	☐	☐	Headaches	☐	☐	Kidney Stones	☐	☐
Eye Pain/Problems	☐	☐	Dizziness/Vertigo	☐	☐	Decreased Sex Drive	☐	☐
Jaundice	☐	☐	Tendency to Faint Easily	☐	☐	Increased Sex Drive	☐	☐
Difficulty digestion of oily foods	☐	☐	Sweat Easily	☐	☐	Hair Loss	☐	☐
Gall Stones	☐	☐	Strong Thirst	☐	☐	Urinary Problems	☐	☐
Light Colored Stools	☐	☐	Depression	☐	☐	Fatigue	☐	☐
Pain/Coldness in Genitals	☐	☐	Anxiety	☐	☐	Edema/Ankle Swelling	☐	☐
Soft or Brittle Nails	☐	☐	Eating Disorder	☐	☐	Blood in Stool	☐	☐
Cold Hands/Feet			Sudden weight loss			Black/Tarry Stools		
Easily Angered/Agitated	☐	☐	Sudden weight gain	☐	☐	Difficult to stop bleeding	☐	☐
						Intolerance to weather change	☐	☐

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WOMEN'S SURVEY

Age of first period:		Are you pregnant?
Age of last period (menopause):		Are you currently trying to conceive?
Length of Cycle:		# pregnancies: # live births:
Number of days of flow:		# miscarriages: # abortions:
Color of flow:		
Date of Last Gynecologic Exam:		Date of Last Mammogram:
Date of Last Pap Smear:		Date of Last Bone Density Scan:
Please list any abnormal results:		Please list any abnormal results:

Are you currently taking birth control pills, or using a hormone patch? Yes / No #_____ years

For what reason did you begin using them? _____

Have you been diagnosed with (please circle):

Fibroids / Endometriosis / Fibrocystic Breasts / Ovarian Cysts / PCOS / Pelvic Inflammatory Disease

Check off if you have the following symptoms related to your menses or PMS:

Vaginal Discharge	☐	Swollen/Painful Breasts	☐	Increased Sex Drive	☐
Nausea	☐	Poor Sleep/Insomnia	☐	Decreased Sex Drive	☐
Low Appetite	☐	Clots in Menstrual Flow	☐	Hot Flashes	☐
Increased Appetite	☐	Painful Periods	☐	Night Sweats	☐
Vomiting	☐	Vaginal Dryness	☐	Excessive Menstrual Flow	☐
Loose Stools/Diarrhea	☐	Mood Swings	☐	Scanty Menstrual Flow	☐
Constipation	☐	Headaches	☐	Spotting between periods	☐

Please list any other symptoms you are having:

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FAMILY/MEDICAL HISTORY

Please indicate if you or a blood relative has been diagnosed with any of these significant illnesses:

DISEASE	ME	RELATIVE	DISEASE	ME	RELATIVE
Hepatitis	☐	☐	Cancer	☐	☐
High Blood Pressure	☐	☐	Autoimmune Disease	☐	☐
Diabetes	☐	☐	Seizures	☐	☐
Heart Disease	☐	☐	HIV/AIDS	☐	☐
Emotional Disorders	☐	☐			

Please list any serious illnesses/hospitalizations/surgeries:

_____ Date: _____

_____ Date: _____

_____ Date: _____

Do you have a pacemaker or defibrillator? Yes / No

Are you taking Warfarin/Coumadin/Blood Thinners? Yes / No

Are you taking Lithium? Yes / No

ALLERGIES

List any substance to which you are allergic including foods, environmental triggers & medications Please include if you have any metal allergies.

SOCIAL BACKGROUND:

Do you use:

Coffee/Black Tea	Yes/No	#____/week	Alcohol	Yes/No	#____/week
Tobacco	Yes/No	#____/week	Non-Medical Drugs	Yes/No	#____/week
Soda	Yes/No	#____/week	OTC Pain Meds	Yes/No	#____/week

List any health problems/ongoing health concerns not already mentioned:

_____

_____

Is there anything else you'd like me to know about your life, or your reasons for seeking acupuncture?

_____

_____

If there are changes to any of the above, I agree to inform my acupuncturist as well as my Medical Doctor.

_____ Date:_____

Signature