Halo Salt Spa

New Acupuncture Client Questionnaire

This confidential questionnaire will assist us in designing an individual treatment to best suit you. Thank you for taking the time to thoroughly fill in each question.

PERSONAL INFORMATION

❑ Ms. ❑ Mrs. ❑ Mr. Name:

Address: Apt #

City: State: Zip:

Home Phone: Alternate Phone:

Email:

Date of Birth: / / Place of Birth:

Emergency Contact:

Any known complications at birth:

Occupation:

Occupational Stress: ❑ chemical ❑ physical ❑ psychological Other:

How many hours/week do you work? Are you satisfied with your job?
❑ Yes ❑ No

Marital Status: ❑ single ❑ married ❑ divorced ❑ widowed ❑ mutually committed

Have you ever had acupuncture? ❑ Yes ❑ No, when?

For what condition?

Was it a good experience? ❑ Yes ❑ No

How were you referred to us?

Can we contact him/her to thank them for the referral? ❑ Yes ❑ No

GENERAL HEALTH AND TREATMENT HISTORY

What are your reasons/concerns for seeking treatment?

1.-

2.-

3.-

4.-

5.-

hen did your health concerns begin?

Your condition is improved by

Your condition is aggravated by

Are you currently under the care of a physician? ❑ Yes ❑ No

For what condition(s)?

Physician's Name: Address:

City: State: Zip:

Phone: Date of last medical doctor visit: / /

What was the reason for your visit to your medical doctor?

Was there a diagnosis offered?

What other methods of therapy (conventional and alternative) have you used for this condition?

Therapy Therapist name Date / /

Response

Therapy Therapist name Date / /

Response

Therapy Therapist name Date / /

Response

Family Health History (please check all that apply to PARENTS/SIBLINGS):

- ❑ Diabetes Who? ___________________________________
- ❑ Cancer Who? ___________________________________
- ❑ Heart Disease Who? ___________________________________
- ❑ Stroke Who? ___________________________________
- ❑ High Blood Pressure Who? ___________________________________
- ❑ Seizures Who? ___________________________________
- ❑ Asthma Who? ___________________________________
- ❑ Allergies Who? ___________________________________
- ❑ Other ___________________________________

Personal Significant illnesses (please check all that apply TO YOU):

- ❑ Allergies To: ______________
- ❑ Cancer
- ❑ Diabetes: ❑Type I (insulin usage) ❑Type II
- ❑ Hepatitis: ❑ A ❑ B ❑ C
- ❑ Heart Disease
- ❑ Stroke
- ❑ Seizures
- ❑ HIV / AIDS
- ❑ Pneumonia
- ❑ Tuberculosis
- ❑ Multiple sclerosis
- ❑ Thyroid
- ❑ Asthma
- ❑ Stomach Ulcers
- ❑ Obesity
- ❑ Depression
- ❑ Shingles
- ❑ Chronic Fatigue
- ❑ Rheumatic Fever
- ❑ High Blood Pressure
- ❑ STD's
- ❑ Other ___________

Please list any **surgical procedures** you have had:

Surgery Date

Surgery Date

Surgery Date

Surgery Date

Please list **prescribed** medications you are currently taking and for what condition:

Medication_____________________Condition________________________________
Medication_____________________Condition________________________________
Medication_____________________Condition________________________________
Medication_____________________Condition________________________________
Medication_____________________Condition________________________________

Please list **over-the-counter** medications you are currently taking and for what condition:

Medication______________________Condition__________________________________
Medication______________________Condition__________________________________
Medication______________________Condition__________________________________
Medication______________________Condition__________________________________
Medication______________________Condition__________________________________

Please list any **vitamins, supplements, and herbs** you are taking:

Product______________________Condition____________________________________
Product______________________Condition____________________________________
Product______________________Condition____________________________________
Product______________________Condition____________________________________
Product______________________Condition____________________________________

Please mark in the following table how often do you experience the listed emotions and what is the usual cause that triggers them:

Emotion	**Never**	**Sometimes**	**Often**	**Always**	**Caused by**
Happy					
Peaceful					
Anxious					
Relaxed					
Joy					
Anger					
Fear					
Worry					
Depression					
Sadness					

Rate your stress level regarding the following matters.
(Use a 1-10 scale, 0 being no stress, 5 moderate and 10 extremely stressful)

Work	**Health**	**Love**	**Money**	**Family**	**The future**	**General**

DIET, EXERCISE & LIFESTYLE

Do you have a regular exercise program? ❑ Yes ❑ No. Please, describe:

How many meals do you have per day? How many snacks?

Are you or have you ever been on a restricted diet? ❑ Yes ❑ No. What kind?

What foods/flavors do you crave?

Please describe your average daily diet:

Morning	Afternoon	Evening

Dietary preferences:

___ Vegetarian
___ Vegan
___ Raw foods diet
___ Low fat diet
___ High protein/low carb
___ Dairy /milk /cheese
___ Eggs
___ Chicken
___ Fish / seafood
___ Red meat
___ Artificial sweeteners
___ Fast food/ burgers/ fries
___ Spicy / hot
___ Sweet
___ Sour
___ Salty
___ Cold drinks
___ Hot drinks
___Ice chewing
___Extreme thirst
___Thirst with no desire to drink

Do you take any of the following:

Coffee: ❑ Yes ❑ No #____/week ❑ Regular ❑ Decaf
Alcohol: ❑ Yes ❑ No #____/week What? ___________
Soda: ❑ Yes ❑ No #____/week ❑ Diet ❑ Regular
Cigarettes: ❑ Yes ❑ No #____/day (Brand:________)
Recreational Drugs: #____/week (Type:_________________)

How is your sleep:

- ❑ I sleep well.
- ❑ It's hard to fall sleep
- ❑ It's hard to stay sleep
- ❑ I wake up every night at ___________
- ❑ I wake up refreshed
- ❑ I wake up tired

How many hours/night do you sleep? ______ What time do go to bed? ____________

Do you have recurring dreams? ❑ Yes ❑ No. If yes, explain:

Do you use any of the following products?

- ❑ anti-perspirant
- ❑ hair dyes/permanents/relaxers
- ❑ cellular phone, #of mins per day______________
- ❑ computer, # hours per day___________________
- ❑ commercial household cleaning products

Mark any of the following conditions that applies to you in the present or past:

General conditions

___ Fatigue
___ Sweat without exertion
___ Night sweats
___ Fever / chills
___ Dizziness / vertigo
___ Bleed / bruise easily
___ Low immunity
___ Other ____________

Digestion

___ Extreme appetite
___ No appetite
___ Cravings
___ Dieting
___ Tired after eating
___ Bloating
___ Gas
___ Acid regurgitation
___ Heartburn/Ulcers
___ Nausea
___ Vomiting
___ Bulimia
___ Irritability or low energy between meals
___ Other ____________

Intestinal

___ Daily Bowel movement
___ Diarrhea
___ Constipation
___ Hemorrhoids
___ Anal itching / burning
___ Laxative use
___ Bloody stool
___ Mucous in stool
___ Contain undigested food
___ Anal fissures
___ Intestinal pain/cramping
___ Incomplete evacuation
___ Hard to push out
___ IBS
___ Colitis
___ Gout
___ Gallstones
___ Other __________

Sleep

___ Fall asleep easily
___ Lie in bed with eyes open
___ Wake at specific times
___ Wake repeatedly
___ Wake frequently to urinate
___ Vivid or Lucid Dreams
___ Wake up not feeling rested
___ Nightmares or frightening dreams
___ Need drugs or supplements to fall asleep

Head, Eyes, Ears, Nose and Throat

___ Dry eyes

___ Spots / flowery vision
___ Blurred vision
___ Poor vision
___ Eye strain
___ Night blindness
___ Cataracts
___ Macular degeneration
___ Bleeding gums
___ TMJ
___ Sores on tongue or mouth
___ Dry mouth
___ Excess saliva
___ Sinus problems
___ Post-nasal drip
___ Sore throat
___ Headaches
___ Swollen glands
___ Difficulty swallowing
___ Earaches
___ Tinnitus / ringing
___ Deafness
___ Nosebleed
___ Other_________________________

Cardiovascular / respiratory
___ Heart palpitations
___ Chest pain
___ Difficulty breathing
___ High cholesterol
___ Varicose veins
___ Blood clots
___ Swollen ankles
___ Heart valve abnormality
___ Shortness of breath
___ Cold hands / feet
___ Dry cough
___ Wheezing
___ Chest tightness
___ Difficult inhalation
___ Difficult exhalation
___ Productive cough(color of phlegm?)
___ Other ____________

Skin / hair (cont. in next right column)
___ Dry skin
___ Rashes / hives
___ Eczema
___ Psoriasis
___ Pimples / acne
___ Fungal infections
___ Brittle nails
___ Ridged nails
___ Hair loss
___ Dandruff
___ Other _____________

Musculoskeletal
___ Spinal pain
___ Joint pain
___ Tendonitis
___ Swelling
___ Arthritis
___ Limited range of motion
___ Vertebral disc degeneration
___ Osteoporosis
___ Numbness
___ Carpal tunnel
___ Other _____________

Neuropsychological
___ Anxiety
___ Irritability
___ Insomnia
___ Depression
___ Easily stressed
___ Poor memory
___ Seasonal mood disorder
___ Tics
___ Tremors
___ Death of someone close
___ Job stress
___ Recent divorce
___ Currently in therapy
___ Financial setback
___ Other _____________

Genito-urinary
___ Urine Clear
___ Urine Cloudy
___ Urine Dark
___ Painful urination
___ Frequent urination
___ Loss of urine when laughing/sneezing
___ Incomplete urination / retention
___ Dribbling
___ Burning urination
___ Blood in urine
___ Wake frequently to urinate
___ Kidney stones
___ Bedwetting
___ Decreased libido / sexual desire
___ Impotency
___ Infertility
___ Other _____________

MEN ONLY

❑ feeling of coldness

❑ pain or swelling of testicles

❑ numbness in testicles/penis

❑ impotence/erectile dysfunction

❑ premature ejaculation

❑ difficulty starting urine flow

❑ Urinary dribbling

WOMEN ONLY

Are you pregnant now? ❑ Yes ❑ No

Age of first period_______

Number of children _______

Number of pregnancies_______

Age of menopause_______

Is/was your menstrual cycle regular?
❑ Yes ❑ No
Cycle length: ________ days

Average number of days of flow_______

The flow is/was:
❑ normal ❑ heavy ❑light

Does the flow contain:
❑ blood clots ❑ mucous

The color is/was ❑ normal ❑ pink
❑ bright red ❑ dark ❑ purple
❑ light brown ❑ dark brown

Do you experience the following:
❑ abdominal cramps ❑ nausea ❑ pms
❑ bleeding between periods
❑ heavy vaginal discharge between periods
❑ breast distention
❑ sadness / moodiness before/during period