



## Welcome to Healing Paradise Acupuncture

Here at Healing Paradise we strive to be empowered healing practitioners who foster compassionate care, respect and empathy in order to allow individuals to take ownership of their health. By blending the body, mind and spirit philosophy, we focus on the physical, mental, emotional aspect of every individual to allow every patient to leave balanced and toward a state of paradise free from pain, discomfort, anxiety and stress. Getting back on the path to health is a journey; we thank you for making Healing Paradise your destination.

### Personal Information

Name \_\_\_\_\_

Date \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zipcode \_\_\_\_\_

Phone Number \_\_\_\_\_

Email Address \_\_\_\_\_

Emergency Contact \_\_\_\_\_

Emergency Contact # \_\_\_\_\_

Age \_\_\_\_\_

Sex:  Male  Female  Trans \_\_MTF \_\_FTM

Height \_\_\_\_\_ Weight \_\_\_\_\_

Marital Status:  Married  Single  Divorced  Widowed  Partnered

### How did you hear about us?

Word of Mouth  Facebook  Community Event \_\_\_\_\_  Friend \_\_\_\_\_

Physician/Medical Group \_\_\_\_\_  Local Business \_\_\_\_\_

Other \_\_\_\_\_  Other \_\_\_\_\_

### Pre Acupuncture Questionnaire

Have you had acupuncture before?  YES  NO If so, where \_\_\_\_\_

Have you eaten before coming to this appointment?  YES  NO

Where you referred by a physician?  YES  NO Physician Name: \_\_\_\_\_

Have you ever experienced orthostatic hypotension, dizziness or fainting spells?  YES  NO

How much change are you willing to/able to make at this time to improve your health? (Please circle)

Minimal Some Complete



Please review the following symptoms and mark F – Frequently O- Occasionally N- Never

<input type="checkbox"/> Bloating	<input type="checkbox"/> Gassiness	<input type="checkbox"/> Lack of Appetite	<input type="checkbox"/> Excessive Appetite	<input type="checkbox"/> Indigestion	<input type="checkbox"/> Heartburn
<input type="checkbox"/> Loose Stools	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Vomiting	<input type="checkbox"/> Belching	<input type="checkbox"/> Reflux	<input type="checkbox"/> Abdominal Pain

<input type="checkbox"/> Knee Pain	<input type="checkbox"/> Hearing Impairment	<input type="checkbox"/> Kidney Stones	<input type="checkbox"/> Hair Loss	<input type="checkbox"/> Edema	<input type="checkbox"/> Genital Pain
<input type="checkbox"/> Back Pain	<input type="checkbox"/> Ear Ringing	<input type="checkbox"/> Decreased Sex Drive	<input type="checkbox"/> Urinary Problems	<input type="checkbox"/> Fatigue	<input type="checkbox"/> Constant sense of fear or anxiety

<input type="checkbox"/> Heart Palpitations	<input type="checkbox"/> Chest Pain	<input type="checkbox"/> Insomnia	<input type="checkbox"/> Difficulty Falling Asleep	<input type="checkbox"/> Dizziness	<input type="checkbox"/> Eye Problems
<input type="checkbox"/> Cold Hands and Feet	<input type="checkbox"/> Mental Restlessness	<input type="checkbox"/> Nightmares	<input type="checkbox"/> Difficulty Staying Asleep	<input type="checkbox"/> Tendency to faint easily	<input type="checkbox"/> Headaches

<input type="checkbox"/> Cough	<input type="checkbox"/> Feeling of Claustrophobia	<input type="checkbox"/> Bloody Noses	<input type="checkbox"/> Asthma	<input type="checkbox"/> Skin Problems	<input type="checkbox"/> Feelings of grief
<input type="checkbox"/> Shortness of Breath	<input type="checkbox"/> Nasal Problems	<input type="checkbox"/> Allergies	<input type="checkbox"/> Tendency to catch colds	<input type="checkbox"/> Intolerance to Wind	<input type="checkbox"/> Chills and fever

<input type="checkbox"/> Hemorrhoids	<input type="checkbox"/> Gallstones	<input type="checkbox"/> Easily Angered	<input type="checkbox"/> Muscle Spasms	<input type="checkbox"/> Jaundice	<input type="checkbox"/> Muscle Weakness
<input type="checkbox"/> Constipation	<input type="checkbox"/> Soft or brittle nails	<input type="checkbox"/> Difficulty Making Decisions	<input type="checkbox"/> Sciatica Pain	<input type="checkbox"/> Difficulty Digesting Foods	<input type="checkbox"/> Heat or Cold Intolerance

<input type="checkbox"/> Foggy headed	<input type="checkbox"/> Floaters	<input type="checkbox"/> Tinnitus	<input type="checkbox"/> Excessive Thirst	<input type="checkbox"/> Poor concentration
<input type="checkbox"/> Hot hands and feet	<input type="checkbox"/> Numbness and Tingling	<input type="checkbox"/> Neck/Shoulder Tension	<input type="checkbox"/> Never thirsty	<input type="checkbox"/> Excessive Sweating



**Diet/Lifestyle**

Please describe your typical diet:

Breakfast:

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Lunch:

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Dinner:

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Snacks:

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# meals per day: \_\_\_\_\_ # snacks per day: \_\_\_\_\_

Are there other restrictions to your diet? \_\_\_\_\_

Do you experience any gas, burping, bloating acid reflux or other digestive symptoms after eating any foods? \_\_\_\_\_

Do you use tobacco? \_\_\_\_\_ How many times per day/week? \_\_\_\_\_

Have you used tobacco in the past? \_\_\_\_\_ When did you stop? \_\_\_\_\_

Do you drink alcoholic beverages? How many drinks do you have per day/week? \_\_\_\_\_

Do you use recreational drugs? \_\_\_\_\_ How many times per day/week/month/year? \_\_\_\_\_

\_\_\_\_\_ # hours you sleep per night: \_\_\_\_\_

Do you sleep well? \_\_\_\_\_ Do you awake feeling rested? \_\_\_\_\_

**Stress/ Lifestyle**

What is your average stress level (1 is low, 10 is high)? 1 2 3 4 5 6 7 8 9 10

What is your average energy level (1 is low, 10 is high)? 1 2 3 4 5 6 7 8 9 10

At what time of day is your energy typically at its best? \_\_\_\_\_ At its worst? \_\_\_\_\_

How do you feel about the following areas of your life? Rate 1 – 10 (1 is poor, 10 is excellent)?

Health:

Sex :

Family:

Spirituality:

Exercise:

Companionship



**Medications/ Supplements/ Past Medical History**

Please list all prescriptions and over the counter medications you are taking

Name	Dosage	Reason for Taking	Date Started

Please list any vitamins, supplements or minerals that you are taking (Please include energy drinks)

Name	Dosage	Reason for Taking	Date Started

Please list any injuries and/or accidents

Name	Dosage	Reason for Taking	Date Started

**Please indicate if you are taking the following**

- Blood thinners (Warfarin, Coumidin,etc)     Cortisone or steroids     Sleeping Aids  
 Laxatives                       Pain Relievers (Tylenol, Advil)                       Thyroid Medication

Please list any diseases which you have been medically diagnosed with including the date of diagnosis

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**Please circle any areas on the body chart which you feel pain or tension**

