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 of Birth** _____

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 Questionairre

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

□Bloating	□Gassiness	□Lack of Appetite	□Excessive Appetite	□Indigestion	□Heartburn
□Loose Stools	□Diarrhea	□Vomiting	□Belching	□Reflux	□Abdominal Pain

□Knee Pain	□Hearing Impairment	□Kidney Stones	□Hair Loss	□Edema	□Genital Pain
□Back Pain	□Ear Ringing	□Decreased Sex Drive	□Urinary Problems	□Fatigue	□Constant sense of fear or anxiety

□Heart Palpitations	□Chest Pain	□Insomnia	□Difficulty Falling Asleep	□Dizziness	□Eye Problems
□Cold Hands and Feet	□Mental Restlessness	□Nightmares	□Difficulty Staying Asleep	□Tendency to faint easily	□Headaches

□Cough	□Feeling of Claustrophobia	□Bloody Noses	□Asthma	□Skin Problems	□Feelings of grief
□Shortness of Breath	□Nasal Problems	□Allergies	□Tendency to catch colds	□Intolerance to Wind	□Chills and fever

□Hemorrhoids	□Gallstones	□Easily Angered	□Muscle Spasms	□Jaundice	□Muscle Weakness
□Constipation	□Soft or brittle nails	□Difficulty Making Decisions	□Sciatica Pain	□Difficulty Digesting Foods	□ Heat or Cold Intolerance

□ Foggy headed	□ Floaters	□ Tinnitus	□ Excessive Thirst	□ Poor concentration
□ Hot hands and feet	□ Numbness and Tingling	□ Neck/Shoulder Tension	□ Never thirsty	□ Excessive Sweating

Diet/Lifestyle

Please describe your typical diet:

Breakfast:

_____

Lunch:

_____

Dinner:

_____

Snacks:

_____

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

_____
_____
_____
_____
_____

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