



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 _____ Zip code _____
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



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
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<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
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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? great good fair poor bad significant other
family relations friendships living arrangements self image sex work vacations/time off
exercise spirituality



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

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



