Nancy Barravecchio, LMT., LAc.
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Please fill out this CONFIDENTIAL questionnaire to help me determine the best treatment plan for you. Thank you.

Personal Information

Name:_____ Age: _____ Birth Date:____/____/_____

Address:_____ City_____ State: _____Zip:_____

Phone number: _____ E-mail address: _____

If under 18, person responsible for your account:

Emergency Contact: Name:_____Contact Phone:_____

Whom shall I thank for referring you to my office? _____

Have you had acupuncture therapy before? □ Yes □ No

Please indicate if any of the following pertain to you:

□ Hepatitis □ HIV □ High Blood Pressure □ Seizures □ Pacemaker

□ Blood-Thinning Medication □ Pregnancy

Please indicate how frequently you consume the following:

Coffee: Soda: Water:

Alcohol: Tobacco:

Please list any prescription or over-the-counter medications and supplements you are presently taking:

Medication / Supplement	Reason	For how long now?

Health History

Please indicate your top 3 health concerns for which you are seeking treatment and how long you have been experiencing them:

1. _____
2. _____
3. _____

What other forms of treatment have you sought?

_____

What helps your condition?

_____

What aggravates your condition?

_____

What would you like to achieve from your acupuncture sessions?

_____

As we will discuss, your health transformation is a process.

Please include your short-term health goals:

_____

Please include your long-term health goals:

_____

Please indicate your level of commitment to these goals. (How frequently will you be coming in? Will you carry out suggestions, including dietary modifications, that you may be recommended?)

_____

_____

Please list any surgeries or major health incidents (accidents, etc.) in your life and the date of occurrence:

_____

_____

_____

_____

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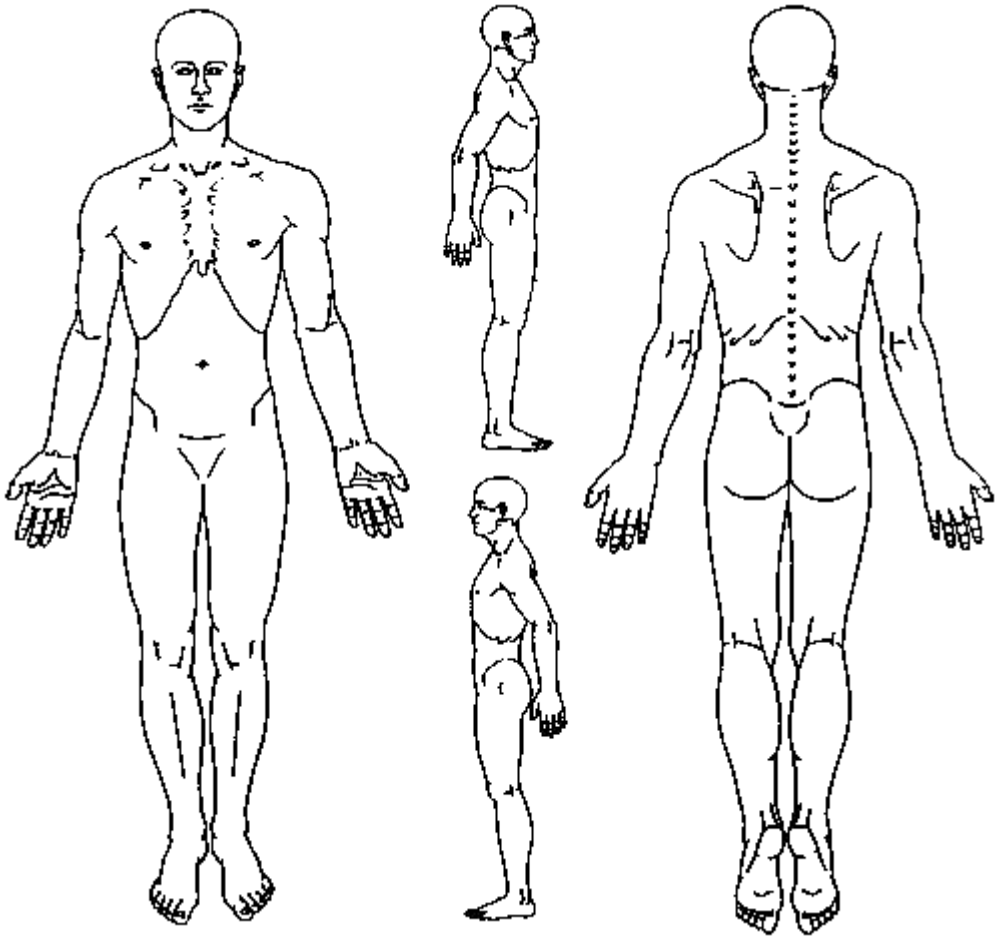
Muscles, Joints & Bones
Do you have pain or tightness? _____ Where?_____
Recent injuries ? _____ Was this from an auto accident or work related?_____

The pain is (check all that apply):Pain Diagram (please mark all areas of pain on diagram below)



If you experience any physical pain, please indicate where and since when:

_____

How would you characterize your physical pain?

□ dull/achy □ sharp/stabbing □ burning □ tingling /numbness □ electrical

□ continuous □ comes and goes □ fixed location □ moves around □ shooting/ radiating

□ Superficial Pain □Better with Heat □ better with Ice □ Better /worse with movement

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Symptoms Survey

Please indicate the symptoms or conditions you currently experience or have experienced them in the past:

Earth	Currently	Past	Wood	Currently	Past
Excessive appetite	□	□	Eye Problems	□	□
Loose stools / diarrhea	□	□	Jaundice	□	□
Digestive problems	□	□	Difficulty ingesting	□	□
Gas or bloating	□	□	Belching	□	□
Obsession	□	□	Acid Reflux / heart burn	□	□
Worry thoughts	□	□	Easily Frustrated/ angered	□	□
Lack of appetite	□	□	Depression	□	□
Fatigue	□	□	Difficulty making decisions	□	□
Low energy after a meal	□	□	Gallstones	□	□
Sweet cravings	□	□	Ringing in the ears	□	□
Hemorrhoids	□	□	Brittle hair or nails	□	□
Low blood pressure	□	□	High cholesterol	□	□

Fire	Currently	Past	Metal	Currently	Past
Insomnia	□	□	Cough	□	□
Heart palpitations	□	□	Shortness of breath	□	□
Nightmares	□	□	Decreased sense of smell	□	□
Mentally restless	□	□	Colitis/diverticulitis	□	□
Chest pain	□	□	Tightness in the chest	□	□
Poor memory	□	□	Constipation	□	□
Sadness/loneliness	□	□	Grief/ Nostalgia	□	□
Agitation/Fidgeting	□	□	Claustrophobia	□	□

Water	Currently	Past	Blood & Dampness	Currently	Past
Lower back pain	□	□	Arthritis	□	□
Knee pain/ problems	□	□	Sluggishness/Grogginess	□	□
Hearing impairment	□	□	Nausea	□	□
High or low libido	□	□	Heavy feeling	□	□
Hair loss	□	□	Dark circles under eyes	□	□
Urinary problems	□	□	Blood clotting disorder	□	□

I usually feel :	□ Hot	□ Cold	□ I'm often thirsty	□ Dry mouth/throat

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For Women

Are you currently sexually active? □ Yes □ No Partners are: □ Men □ Women

Age of first period: Date of last period: Number of days between periods:

Number of pregnancies: Miscarriages: Abortions:

Number of days of flow:

Please indicate color of blood and number of pads/tampons per day of flow below:

	Color: *Pale/light red	* Bright red	* Dark red/brown	Cramping: * Mild	*Moderate	*Severe	# of pads: *1-3	*4-7	*8+
Day 1,2	□	□	□	□	□	□	□	□	□
Day 3,4	□	□	□	□	□	□	□	□	□
Day 5+	□	□	□	□	□	□	□	□	□

Please indicate if you experience the any of these symptoms during your menses:

□ Lower back pain □ Diarrhea □ Constipation □ Moodiness/Weepy □ Breast pain/soreness
□ Blood clots □ Increased appetite □ Decreased appetite □ Headache
□ Nausea □ Insomnia □ More tired □ Hemorrhoids
□ Bloating □ Down-bearing sensation □ Scant or late menses □ Irregular menses

Please indicate if you experience any of these other gynecological symptoms:

□ Vaginal dryness □ Profuse vaginal discharge □ Yeast infections □ Urinary tract infections

Please indicate if you have been diagnosed with any of the following:

□ Fibroids □ Fibrocystic breasts □ Endometriosis □ Ovarian Cysts □ Polycystic Ovary Syndrome
□ Pelvic Inflammatory Disorder

Please list any STDs you have: _____

For Men

Date of your last prostate exam: Are you currently sexually active? □ Yes □ No

Partners are: □ Male □ Female Please list any STDs you have: _____

Please explain any concerns you may have with your sexual function or libido:

_____

_____

Lifestyle

How many hours of sleep do you get each night? _____

Do you experience: □ Difficulty falling asleep □ Staying asleep □ Interrupted sleep

□ Nightmares □ Vivid dreams □ Wake up not well-rested/groggy

How many bowel movements do you have in a day or week?_____

Are your bowel movements: □ Well-formed □ Loose □ Small pebbles □ Tan □ Almost black

□ Easy to pass □ Difficult to pass □ Sticky, like you have to wipe a lot

How would you rate your energy level on a scale of 1-10, with 10 being the highest:_____

How would you rate your stress level on a scale of 1-10, with 10 being the highest:_____

Please list your primary sources of stress: _____

_____

How much do you think about them? How much do they impact your life?

How many hours do you work per week? _____ Do you like your work? _____

What do you do in order to manage your stress and take care of yourself?

Did I miss anything? Anything else you'd like me to know?