

## **Acupuncture Appointments**

- 1. Please bring your new patient questionnaire filled out with you to your first appointment.**
- 2. Please bring or wear loose clothing (shorts, t-shirts) to each appointment.**
- 3. Please eat a light meal or snack before your appointment; an empty stomach may cause dizziness.**
- 4. Please DO NOT eat or drink food that may change the color of your tongue or brush your tongue the day of your appointment. (coffee, soda, juice)**
- 5. Please verify with your insurance company to see if you have acupuncture benefits prior to your treatment. If you do not have coverage ask your insurance company if they will pay if a medical doctor gives you a referral.**

### **What to expect at your first visit?**

**Your first visit will take approximately one hour and will include an acupuncture treatment. We will discuss your health questionnaire and any concerns you have prior to the treatment. I will come up with a diagnosis, a treatment plan and a few suggestions regarding your condition. If you have any questions please do not hesitate to email me at [emily@apointofhealth.com](mailto:emily@apointofhealth.com). I look forward to working with you.**

**Thank you,  
Emily Valenzuela, L.Ac., CCN**

# New Patient Questionnaire

## Acupuncture Intake Form

Date:

*Please help us provide you with a complete evaluation by taking the time to fill out this questionnaire carefully. This information is considered confidential. Please fill it out as completely as possible even if you do not feel certain questions pertain to your present condition. Thank You.*

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Name: \_\_\_\_\_

Address: \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Email: \_\_\_\_\_

Phone: (Cell) \_\_\_\_\_ (Home) \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Sex: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

Employer: \_\_\_\_\_

Occupation: \_\_\_\_\_

Social Security #: \_\_\_\_\_

Single/Married/Divorced/Widowed/Other (circle)

Physician: \_\_\_\_\_

Referred by: \_\_\_\_\_

In Emergency, Notify: \_\_\_\_\_

Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

Insurance Carrier: \_\_\_\_\_ ID# \_\_\_\_\_

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Main problem/s you would like help with:

1.

2.

3.

When did the problem/s begin (be specific):

To what extent does the problem/s interfere with your daily activity (work, exercise, sleep, sex, etc.)?

Have you been given a diagnosis for the problem/s? If so, what?

What kind of treatments have you tried? Other concurrent therapies:

**Medications**

What medications are you currently taking? Please list name, reason, dosage.

**Habits**

Do you have a regular exercise program? Please describe.

Please indicate usage per day or per week:

Water        \_\_\_\_\_ ounces per day  
Coffee        \_\_\_\_\_ ounces per day  
Tea            \_\_\_\_\_ day/week (circle)  
Alcohol       \_\_\_\_\_ day/week    Type liquor/beer/wine  
Soft Drinks \_\_\_\_\_ day/week  
Cigarettes    \_\_\_\_\_ day/week  
Sweets        \_\_\_\_\_ day/week

Please describe your average daily diet: Be specific.

Morning:

Snack:

Lunch:

Snack:

Dinner:

Supplements/Herbs/Vitamins/Minerals: (Please list brand, product name, & reason for taking)

**Muscles/ Bones/ Joints**

Do you have pain or tightness? No / Yes If Yes, please indicate the location on the chart below.

The pain is (circle all that apply):

- |                             |          |                             |           |                                 |
|-----------------------------|----------|-----------------------------|-----------|---------------------------------|
| Sharp                       | Dull     | Aching                      | Numb      | Superficial Pain                |
| Burning                     | Tingling | Shooting                    | Deep Pain | Pain worse in am/pm             |
| Pain worse/better with heat |          | Pain worse/better with cold |           | Pain worse/better with pressure |

I have (circle all that apply):

- |                |                          |            |                                |
|----------------|--------------------------|------------|--------------------------------|
| Swollen joints | Arthritis/joint pain     | Tendonitis | Muscle cramping                |
| Muscle pain    | Repetitive Strain Injury | Bone Pain  | Fractured Bone(s) Where? _____ |

Please explain any injury's in the space provided:

Date of onset:

Location:

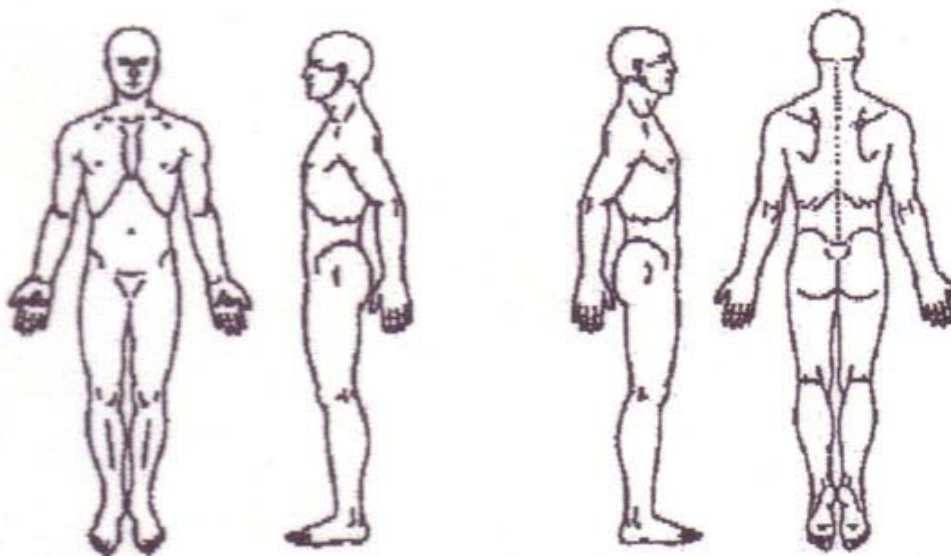
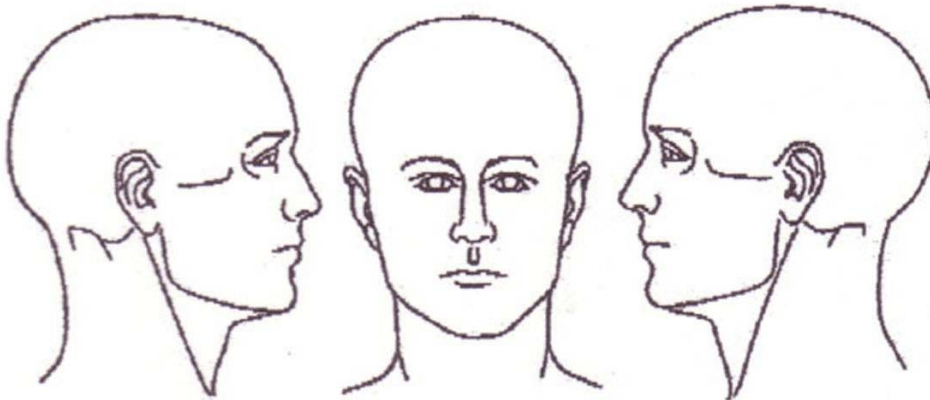
Duration of pain:

Aggravating factors: (ex. Heat)

Alleviating factors: (ex. Cold)

Treatments: (ex. Ibuprofen, chiropractic)

**Please indicate areas of pain or distress:**



**Energy:**

How is your energy? Please circle. low 1 2 3 4 5 6 7 8 9 10 high

What time of day is your energy:

**Highest:** 6am-12pm/1pm-5pm/6pm-12am & **Lowest:** 6am-12pm/1pm-5pm/6pm-12am

Do you fatigue easily? Yes/ No

**Emotions & Sleep:**

How do you feel emotionally?

Do you have (circle all that apply):

Panic attacks	Depression	Anxiety	Bad temper
Nervousness	Fear attacks	Poor memory	Difficult concentration

Are you in a relationship? Yes / No

How do you feel about your relationship? Good/ Fair/ Poor

How do you handle stress?

How do you relax?

How do you feel about your work?

How long do you normally sleep? \_\_\_\_\_ hours per night

I have difficulties with (circle all that apply):

Falling asleep	Staying asleep	Dream-disturbed sleep
Waking up at about _____ am/pm and not being able to fall asleep again		

**Gastrointestinal:**

I have (check all that apply):

Belching	Nausea	Vomiting	Ulcers	Bloating
Heartburn	Hernia	Acid Reflux	Severe stomach pain	Other: _____

Bowel movements: How often? \_\_\_\_\_ time(s)/day or \_\_\_\_\_ days/week

I have (circle all that apply):

Irregular Bowel Movements	Constipation	Diarrhea	Undigested food in stool
Burning sensation	Hemorrhoids	Itchiness	Painful bowel movements
Loose stool	Hard stool	Blood in stool	Gas

**Urination:**

Urination: How often? \_\_\_\_\_ times per day Color: Pale yellow / Dark yellow/orange

I have or had (circle all that apply):

Trouble starting stream	Frequent urination	Incontinence	Dribbling when sneezing
Burning	Pain	Blood in urine	Kidney stones
Urinary tract infections	Other _____		

**Women Only:**

Are you pregnant: Y / N

Age of first menses: \_\_\_\_\_

Number of days between cycles: \_\_\_\_\_

Number of flow days: \_\_\_\_\_ Typical Color: dark red/ bright red/ pale red

I have or had (check all that apply):

Irregular menstruation	Heavy flow	Light flow	No flow	Clots
Vaginal itching/burning	Spotting between periods		Discomfort/pain before period	
Irritability	Breast Tenderness		Cravings	Cramps
Vaginal discharge? No / Yes <input type="checkbox"/> Color _____				

Number of pregnancy's \_\_\_\_\_ Number of Children: \_\_\_\_\_

**Men:**

I have (circle all that apply):

Prostatitis	Impotence	Penis blood/mucous/discharge	Reproductive problems
Other: _____			

**Eyes, Ears, Nose, Throat, & Head:**

Do you smoke? No / Yes \_\_\_\_\_ per day, for \_\_\_\_\_ years

I have (check all that apply):

- |   |                    |                              |                    |                         |
|---|--------------------|------------------------------|--------------------|-------------------------|
| Frequent colds                              | Chronic runny nose | Frequent sore throat         | Chronic cough      | Allergies               |
| Coughing blood                              | Cough up mucous    | Pain inhaling                | Asthma             | Clogged/popping in ears |
| Nose bleeds                                 | Painful/red eyes   | Poor vision                  | See spots/floaters | Dizziness               |
| Bleeding gums                               | Dry mouth          | Ear pain                     | ringing in ears    |                         |
| Shortness of breath on exertion/ or at rest |                    | Frequent headaches/migraines |                    |                         |

**Cardiovascular:**

I have (circle all that apply):

- |                      |                  |                |           |                     |
|----------------------|------------------|----------------|-----------|---------------------|
| Chest pain           | Palpitation      | Varicose veins | Phlebitis | Cold hands and feet |
| Irregular heart beat | Poor circulation | Hypertension   |           |                     |
| Other: _____         |                  |                |           |                     |

**Skin & Hair:**

I have or often have (circle all that apply):

- |           |                   |           |              |        |       |
|-----------|-------------------|-----------|--------------|--------|-------|
| Dry skin  | Skin rashes       | Itching   | Acne         | Eczema | Hives |
| Hair loss | Premature graying | Age spots | Other: _____ |        |       |

## Financial Policy

- As a courtesy, we will bill your insurance company if you have acupuncture benefits. We cannot bill health insurance for conditions that are not covered by your plan. **You are expected to pay on the day of service.** If we receive reimbursement for your treatments they will be applied to your account as a credit or a check can be made out to you. Expect payment within 6-8 weeks of the start of your first treatment.
- A \$45 fee will be charged for missed appointments or cancellations without a 24 hour notification.
- Payment is due at time of service for non-insurance patients.

### FEE SCHEDULE

#### ACUPUNCTURE

##### Adults

Initial Visit	\$100
Initial Visit Military	\$75

Follow-up Visits	\$60
Follow-up Visits Military	\$50

##### Seniors (over 65)

Initial Visit	\$75
Follow-up Visits	\$50

##### Children (under 18)

Initial Visit	\$60
Follow-up Visits	\$45

#### CLINICAL NUTRITION

##### Adults, Children, Seniors

60 minutes	\$80
30 minutes	\$40
15 minutes	\$20

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Signature

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Date

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Please Print Name