Dr. Nicky Acupuncture
229 Jackson St, Suite #134
Anoka MN 55303

Welcome! My goal is to help you achieve your optimum health and wellness.
This is a **confidential** questionnaire to help me
determine the best treatment plan for you

Personal Information

Name_____ Date_____

Home Address_____

City_____ State_____ Zip_____

Primary Phone_____ ☐ Yes, I want Text Message appointment reminders: # _____

Email_____

Occupation_____ Work Phone_____

If a minor, person responsible for & authorized to access minor's account: _____

Additional authorized adult(s): Name / Relationship to Minor/ Phone #_____

Emergency Contact: Name_____ Phone_____

Gender _____ Height_____ Weight_____ Birthdate_____ Age _____

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Partnered Number of Children _____

Have you received acupuncture therapy or dry needling before? ☐ Yes ☐ No

When?_____ With whom?_____

Who should I thank for referring you? _____

May we add you to our newsletter mailing list? Yes, here's my email: _____

What are the main health problems for which you are seeking acupuncture treatment?

_____

_____

_____

What other forms of treatment have you tried? What were the results?

_____

_____

_____

List any other health problems you currently have.

_____

_____

_____

List any medications and supplements you are currently taking. Continue on back if necessary.

Medicine/Supplement	Dose	Reason	How Long	Prescribed by	Date of Last Checkup

Check box if any of the following statements are true:

☐ I have known allergies
☐ I have a pacemaker
☐ I am taking Coumadin/Warfarin
☐ I am taking Lithium

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OB/GYN History

Age of 1st period (menarche)_____
Age of Last period (menopause)_____
# of days between periods_____
# of days of flow_____
Color of Flow_____
Clots ☐ Yes ☐ No Color_____

Are you pregnant ☐ Yes ☐ No ☐ Trying to get pregnant
# of live births_____ # of abortions_____ # of miscarriages_____
Date of last gynecologic exam_____ Pap smear_____
Mammogram_____ Bone Density Scan_____
Results_____
Avg. # of Pads/tampons per days 1st__ 2nd__ 3rd__ 4th__ 5th__ + _____

Have you been diagnosed with: ☐ Fibroids ☐ Fibrocystic Breasts ☐ Endometriosis ☐ Ovarian ☐ Cysts ☐ PID
Other_____

Location of Menstrual Pain: ☐ Lower abdomen ☐ Lower back ☐ Thighs ☐ Other_____

Nature of Pain (indicate Before, During, or After)

Cramping _____ Stabbing _____
Burning _____ Aching _____
Dull _____ Bloating _____
Consistent _____ Intermittent _____
Bearing Down Sensation _____

Other symptoms related to menses:

☐ Ravenous Appetite ☐ Vaginal Dryness ☐ Headache
☐ Poor Appetite ☐ Constipation ☐ Mood Swings
☐ Insomnia ☐ Swollen Breasts ☐ Diarrhea
☐ Increased Libido ☐ Hot Flashes ☐ Night Sweats
☐ Decreased Libido ☐ Nausea ☐ Discharge

Urogenital History

Date of last prostate checkup_____ PSA Results_____
Manual prostate exam results_____ Lab Results_____
Frequency of Urination: Daytime_____ Nighttime_____ Color of urine ☐ Clear ☐ Murky Odor_____

Symptoms Related to Prostate:

☐ Prostate Problems ☐ Delayed Stream ☐ Post Void Dribbling ☐ Incontinence
☐ Retention of Urine ☐ Decreased Force of Stream ☐ Increased Libido ☐ Decreased Libido
☐ Premature Ejaculation ☐ Impotence ☐ Back Pain ☐ Groin Pain
☐ Testicular Pain ☐ Erectile Dysfunction ☐ BPH/Enlarged Prostate

Symptom Survey

The following is a list of symptoms that you may or may not ever experience. Please indicate as follows in the space to the left.

No mark/blank ( ) = never experience, Check Mark (√) = sometimes, Plus Sign (+) = frequently

☐ Lack of Appetite
☐ Excessive appetite
☐ Loose stool or diarrhea
☐ Digestive problems
☐ Vomiting
☐ Belching
☐ Heartburn/reflux
☐ Feeling of food retention in stomach
☐ Tendency to become obsessive in work/relationship
☐ Insomnia, difficulty sleeping
☐ Heart palpitations
☐ Cold hands/feet
☐ Nightmares

☐ Abdominal pain
☐ Chest pains
☐ Sciatic Pain
☐ Headaches
☐ Pain or coldness in genital area
☐ Cough
☐ Shortness of Breath
☐ Decreased sense of smell
☐ Nasal problems
☐ Skin problems
☐ Feeling of claustrophobia
☐ Bronchitis
☐ Colitis or diverticulitis

☐ Eye issues
☐ Jaundice (yellowish skin/eyes)
☐ Difficulty digesting oily foods
☐ Gall stones
☐ Light Colored Stools
☐ Soft or brittle nails
☐ Easily angered or agitated
☐ Difficulty in making plans or decisions
☐ Spasms or twitching muscles
☐ Low back pain
☐ Knee problems
☐ Hearing impairment
☐ Ear ringing

☐ Fatigue
☐ Edema
☐ Blood in stool
☐ Black tarry stool
☐ Easily bruised
☐ Difficult to stop bleeding
☐ Asthma
☐ Tendency to catch colds easily
☐ Intolerance to weather changes
☐ Allergies
☐ Hay fever
☐ Dizziness
☐ Tendency to faint easily

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☐ Mentally restless	☐ Constipation	☐ Kidney stones	☐ High cholesterol levels
☐ Laughing for no apparent reason	☐ Hemorrhoids	☐ Hair loss	☐ Sudden weight loss
☐ Angina pains	☐ Recent antibiotic use	☐ Decreased sex drive	☐ Other_____
☐ Other_____	☐ Other_____	☐ Urinary problems	☐ Other_____

Please indicate the USE and FREQUENCY of the following:

	Yes	No	How Much & Often		Yes	No	How Much & Often
Coffee/ Black tea	☐	☐	_____	Alcohol	☐	☐	_____
Non-Medicinal Drugs	☐	☐	_____	Soda	☐	☐	_____
Tobacco / Vape	☐	☐	_____	Water Intake	☐	☐	_____

Please indicate any significant illnesses you or a blood relative (grandparent, parent, sibling) have had:

Illness	You	Relative	Approx. Date	Illness	You	Relative	Approx. Date
Cancer	☐	☐	_____	Diabetes	☐	☐	_____
Hepatitis	☐	☐	_____	Heart Disease	☐	☐	_____
High Blood Press	☐	☐	_____	Seizure	☐	☐	_____
Rheumatic Fever	☐	☐	_____	Emotional Disorders	☐	☐	_____
Infectious Disease	☐	☐	_____	Tuberculosis	☐	☐	_____

Sexually Transmitted Infections: ☐ Gonorrhea, ☐ Syphilis, ☐ HIV, ☐ HPV, ☐ Chlamydia, ☐ Herpes, ☐ Other_____

List any allergies, food sensitivities or food cravings that you have.

_____
_____
_____

List any accidents, surgeries, or hospitalizations (include date).

_____
_____
_____
_____

How do you FEEL about the following areas of your life?
Please check the appropriate boxes and indicates any problems you may be experiencing.

	Great	Good	Fair	Poor	Bad	Your Comments
Significant Other	☐	☐	☐	☐	☐	_____
Family	☐	☐	☐	☐	☐	_____
Diet	☐	☐	☐	☐	☐	_____
Sex	☐	☐	☐	☐	☐	_____
Self	☐	☐	☐	☐	☐	_____
Work	☐	☐	☐	☐	☐	_____
Exercise	☐	☐	☐	☐	☐	_____
Spirituality	☐	☐	☐	☐	☐	_____

Other information you would like to report/may be relevant to your medical history?

_____
_____
_____