Joanne Neville L.Ac.

Licensed Acupuncturist & Herbalist



Patient Information:

Name:		Date:	
Age:	Date of Birth:	Social Security #:	
Address:			
Primary Phon	e:	□ Home □ Work □	
Cell OK to lea	ve a message? □ Yes □ No		
Secondary Ph	one:	□ Home □ Work □	
Cell OK to lea	ve a message? □ Yes □ No		
Email:			
Occupation: _		Student? □ Yes □ No	
Referred By:			
* If patient is a	child, please list parent's name	here:	
r delette er r di	ent dignature.		
5 0			
<u>Emergency Cor</u>	ntact Information		
Name & Rela	tionship:	Phone:	
Primany Physicis	an's Namo:		
Phone:		Fax:	

0	What are your long- and short-term goals here?
0	What is your primary complaint or complaints?
0	When did the symptoms begin?
0	What precipitated or started the condition?
0	Does anything make it better or worse? (i.e. time of day, heat/cold, activity, season of the year, emotion, or position)
0	Is it worse on one side of the body?
0	Can you think of any other complaints or problems, even though they may seem insignificant or be unrelated to your primary complaint(s)?
0	Please list any prior surgeries or hospitalizations and their date(s):
0	Do you have any allergies (food, environmental, seasonal, etc.)?

Please check the appropriate box for each condition/symptom listed below:

<u>Legend</u>

C = Currently experiencing this

P = Past (experienced this in the past, but not currently)

B = Both (experiencing this currently <u>and</u> experienced this in the

past) N = Never experienced this

Condition/Symptom/Experience	C	P	В	N
Pain, palpitations, tightness or other sensations in your chest				
Shortness of breath				
Aches or pain in your neck, middle back, or low back				
Pain, numbness, or tingling in your arms or legs				
Injury or car accidents				
Concussion or hitting your head				
Eating disorders such as bulimia, anorexia, or compulsive eating				
Heartburn or nausea				
Distress in upper abdomen or stomach				
Diarrhea or loose stools				
Constipation or having less than one bowel movement per day				
Problems with gas or belching				
Burning, pain, or urgency with urination (or if male, with ejaculation)				
Sexually transmitted infections (i.e. HPV, gonorrhea, herpes, etc.)				
Exposure to chemicals, pesticides, etc.				
Physical, sexual, or emotional abuse				

Do you get neadacnes? Li Yes Li No
If Yes, how often: Location:
Do you have any tattoos? ☐ Yes ☐ No (If Yes, when did you get them:
Have you ever had a blood transfusion? \square Yes \square No
Have you ever served in the military? \square Yes \square No
Do you ever cry? \square Yes \square No (If Yes, do you prefer to: \square be alone \square be comforted)
What is your predominant emotion? \Box Joy \Box Anger \Box Fear \Box Sadness \Box Worry
Do you have a regular exercise program? \square Yes \square No
If Yes, how many days per week:and what type/intensity of exercise:
For Females:
Do you menstruate? ☐ Yes ☐ No
What age did you start menstruating?
Do you have an irregular period? ☐ Yes ☐ No
Before your period, do you have:
Breast tenderness? \square Yes \square No Cravings? \square Yes \square No Bloating? \square Yes \square No
Irritability? \square Yes \square No Night sweats? \square Yes \square No
During your period, do you have:
Painful cramps? ☐ Yes ☐ No
A heavy flow? ☐ Yes ☐ No
Clots? ☐ Yes ☐ No
How many days is your typical cycle?
How many days of flow do you have?
Have you ever been pregnant? ☐ Yes ☐ No
If Yes, how many times have you had:
A live birth:
A miscarriage:
An abortion:
If you are in menopause, what age did you stop menstruating?
Do you have:
Hot Flashes? ☐ Yes ☐ No
Vaginal Dryness? ☐ Yes ☐ No
Post-Menonausal Snotting? ☐ Ves ☐ No

Sleep Habits				
Do you sleep well? ☐ Yes ☐ No				
If no, do you have trouble getting to sleep or staying asleep?				
How many hours a night do you sleep?				
Do you take naps? ☐ Yes ☐ No (If Yes, how many or how long:)				
What position do you sleep in at night? \square Back \square Stomach \square Side \square Other:				
Do you often remember your dreams upon waking? □ Yes □ No				
Eating Habits				
Do you eat the following:				
Dairy products (milk, yogurt, cheese, etc.)? ☐ Yes ☐ No				
Red meat (beef, venison, lamb, pork)? \square Yes \square No (circle each type)				
Fish or fowl (tuna, salmon, chicken, turkey)? \square Yes \square No (circle each type)				
Eggs? \square Yes \square No (If Yes, \square Free Range \square Caged)				
Commercially canned food? ☐ Yes ☐ No				
Fruit or vegetable juice? ☐ Yes ☐ No				
Products made with flour (pasta, bread, cereal, etc.)? \square Yes \square No				
Vegetables and legumes? ☐ Yes ☐ No				
Fruit? ☐ Yes ☐ No (If Yes, how many pieces/day?				
Whole grains (brown rice, millet, oats, etc.)? \square Yes \square No				
Soy products (tofu, soy milk, tempeh)? ☐ Yes ☐ No				
Please mark how often you consume these items:				
Sugar: Soda/Soft Drinks:				
Pastries/Cookies/Cake: Ice Cream:				
Coffee:				
Alcohol: (Type & quantity)				
Recreational Drugs: (Type & quantity)				

Diet Diary

Please list EVERYTHING you EAT and DRINK for three (3) full days:

	Day 1	Day 2	Day 3		
Breakfast					
Lunch					
Dinner					
Snacks					
Water Consumption					
Please list your curi	rent prescription medication:	s and their dosages:			
Please list any vitar	nins, minerals, or supplemen	ts that you take:			
Lifestyle Questions					
Do you use an elec	tric blanket? □ Yes □ No				
What kind of water	do you typically drink? 🗆 Fi	ltered □ Bottled □ Tap			
Do you use anti-pe	rspirant? □ Yes □ No				
Do you smoke or c	hew tobacco? ☐ Yes ☐ No	(If Yes, how much/day?)		
Have you regularly smoked or chewed tobacco in the past? \square Yes \square No					

Patient History & Timeline

In the space below, please write out a brief timeline of your history.

(Begin with your birth and early childhood, include any major illnesses, injuries, or hospitalizations, and continue the present time. Be sure to list significant turning points or major events in your life. Also include any periods o heavy usage of alcohol, cigarettes, coffee, and pharmaceutical or recreational drugs. For women, please incl				
events related to your reproductive system such as first period, birth control, pregnancies, miscarriages, abortio and menopause. If you are filling this out for your child, please include specific information about their pregnabirth, and breastfeeding experiences.)				

Family History

Please list any ailments that have affected your relatives. (If you were adopted, please complete this section based on any known information about your biological family.) Please list your relatives' current age, or age they were at death.

	Relative	Ailment	Age			
	Mother					
	Father					
	Brother(s)					
	Sister(s)					
	Maternal Grandmother					
	Maternal Grandfather					
	Maternal Aunts/Uncles					
	Paternal Grandmother					
	Paternal Grandfather					
	Paternal Aunts/Uncles					
Do you have a spouse/partner? ☐ Yes ☐ No If Yes, please list their name, age, occupation, significant health information:						
D	Do you have any children? ☐ Yes ☐ No					
If Yes, please list their names, ages, significant health information:						
_						
D	Do you have any pets? ☐ Yes ☐ No					
lf	If Yes, please list their name and type of animal:					

Thank you for taking the time to complete this questionnaire. Please remember to bring this with you to your initial appointment. If you have questions about this form or your appointment, please call: 303-652-0736.