Magnolia Acupuncture Clinic

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Covington, La 70433
(985) 590-5172

New Patient Questionnaire

This information will be kept confidential

Personal Information

Name: _____ Today's Date: ____/____/____

Age: _____ Birth Date: ____/____/____ Gender: ❑M ❑F Height:_____ Weight _____

Marital Status: ❑Single ❑Married ❑Divorced ❑Widowed

Address: _____

City: _____ _____ State:_____ Zip:_____

Home Phone: (_____)_____ Cell Phone: (_____)_____ Email:_____

Occupation: _____ Employer: _____

How long employed there? _____ Work Phone: (_____)_____ Ext: _____

Physician Name: _____ Specialty: _____ Phone: (_____)_____

Emergency Contact: _____ Relationship: _____ Phone: (_____)_____

How did you hear about Magnolia Acupuncture Clinic? _____

(If there is someone in particular we need to thank, please be sure to give us his or her name)

Have you ever received acupuncture and/or herbal therapy before? ❑Yes ❑No

Main Complaint

What is your main complaint today? _____

How long have you had this problem? _____

What triggered the problem?_____

What makes it better?_____ Worse?_____

If you have seen any other health professional about this issue, please explain what type of practitioner, and results_____

_____

Do you have any other complaints that you would like to address? (list in order of priority)

Complaint	How long?	What triggered it?
_____	_____	_____
_____	_____	_____
_____	_____	_____

Patient Name_____

Personal/Social History

Please indicate usage per day:

Water _____ oz per day
Coffee _____cups per day
Soft drinks _____ per day
Cigarettes/Tobacco _____per day . How long?_____
Alcohol _____ (please indicate type & amount consumed)
Recreational Drugs _____

Family Medical History

Please indicate any major medical conditions (diabetes, cancer, heart conditions, etc) that **your family members** have had:

Mother_____

Father_____

Maternal Grandmother/Grandfather_____

Paternal Grandmother/Grandfather_____

Other_____

Medical History

Please indicate if any of the following conditions apply to you:

❑**Hepatitis** ❑**HIV /AIDS** ❑**Seizures** ❑**Pacemaker** ❑**Blood Thinning meds** ❑**Pregnant/nursing**

Previous hospitalizations/surgeries/serious illness/accidents: Date

_____ _____

_____ _____

_____ _____

Patient Name_____

Please list all medications/supplements/vitamins you are currently taking or have recently taken:

Medication	For what?	How much?	How long?

Please list ALL allergies you have (food, medicine, environmental etc): _____

_____

_____

Please check any conditions you have had and indicate when:

❑ Addiction_____	❑Diabetes	❑Gout	❑Kidney Disease	❑Stroke
❑ Anemia	❑Eating Disorder	❑Heart Disease	❑Liver Disease	❑STD _____
❑ Arthritis	❑Emotional Disturbance	❑Herpes	❑Malaria	❑Thyroid Disease
❑Balance Problems	❑Epilepsy	❑High Cholesterol	❑Meningitis	❑Tuberculosis
❑Bowel Disease	❑Fibromyalgia	❑Hypertension	❑Mononucleosis	❑Other_____
❑ Cancer_____	❑Gall Bladder Disease	❑Hypotension	❑Rheumatic Fever	❑Other_____

Please check/circle any of the following that pertain to you:

Past	Now	General Symptoms
❑	❑	Tired, weak, lack of energy
❑	❑	Frequent colds or illness
❑	❑	Weak or sore knees/low back
❑	❑	Dizziness/ fainting/vertigo
❑	❑	Don't sweat/too much sweat
❑	❑	Hot flashes
❑	❑	Night sweats
❑	❑	Body temp runs hot
❑	❑	Body temp runs cold
❑	❑	Weight gain
❑	❑	Weight loss
❑	❑	Body feels heavy
❑	❑	Cold hands/feet
❑	❑	Hot hands/feet/chest
❑	❑	Other_____

Past	Now	Head, Eyes, Ears
❑	❑	Migraines- front/top/back/sides?
❑	❑	Tension Headache – front/top/back/sides?
❑	❑	Teeth grinding
❑	❑	Jaw pain
❑	❑	Dry/chapped lips
❑	❑	Dry, itchy eyes
❑	❑	Blurry or failing vision
❑	❑	Cataracts
❑	❑	Glaucoma
❑	❑	Ringing in ears
❑	❑	Pain in ears
❑	❑	Loss of hearing
❑	❑	Excessive earwax
❑	❑	Other_____

Patient Name_____

Nose, Mouth, Throat

Past	Now	
❑	❑	Allergies/ itchy or runny nose
❑	❑	Sinus congestion/infections
❑	❑	Frequent nosebleeds
❑	❑	Sores in nose
❑	❑	Cold sores
❑	❑	Mouth/tongue sores
❑	❑	Bleeding/swollen gums
❑	❑	Sore throat
❑	❑	Dry throat
❑	❑	Swollen lymph nodes
❑	❑	Other_____

Skin & Hair

Past	Now	
❑	❑	Acne/pimples
❑	❑	Hives- what triggers?_____
❑	❑	Dry, rough, or scaly skin
❑	❑	Eczema/Psoriasis
❑	❑	Rashes
❑	❑	Skin sores/ulcers
❑	❑	Bruise easily
❑	❑	Dry hair
❑	❑	Thinning hair/hair loss
❑	❑	Other_____

Gastro-Intestinal System

Past	Now	
❑	❑	Loss of appetite
❑	❑	Excessive appetite
❑	❑	Nausea/vomiting
❑	❑	Bad breath
❑	❑	Bitter/metallic/strange taste in mouth
❑	❑	Constipation
❑	❑	Loose stool (Unformed, but not diarrhea)
❑	❑	Diarrhea
❑	❑	Blood or mucus in stool
❑	❑	Black stool
❑	❑	Very pale stool
❑	❑	Undigested food in stool
❑	❑	Foul smelling stool
❑	❑	Feeling of incomplete bowel movement
❑	❑	Gas or bloating
❑	❑	Indigestion
❑	❑	Belching
❑	❑	Hemorrhoids
❑	❑	Abdominal cramping
❑	❑	Acid reflux/GERD/heartburn
❑	❑	Stomach pain
❑	❑	Pain under ribs
❑	❑	Ulcers
❑	❑	Hernia
❑	❑	Other_____

Respiratory System

Past	Now	
❑	❑	Cough- Dry or Phlegm producing?
❑	❑	Shortness of breath
❑	❑	Asthma/wheezing
❑	❑	Phlegm in lungs
❑	❑	Bronchitis
❑	❑	Emphysema/COPD
❑	❑	Difficult to take deep breath
❑	❑	Difficult to breathe lying down
❑	❑	Pain with breathing
❑	❑	Tightness of chest
❑	❑	Sleep Apnea/snoring

Cardiovascular System

Past	Now	
❑	❑	Irregular heartbeat
❑	❑	High blood pressure
❑	❑	Low blood pressure
❑	❑	Palpitations
❑	❑	Chest pain
❑	❑	Heart murmur
❑	❑	Dizziness upon standing
❑	❑	Leg cramps when walking
❑	❑	Hands or feet turn blue sometimes
❑	❑	Swelling of ankles/feet
❑	❑	Swelling of hands
❑	❑	Other_____

Genito-Urinary System

Past	Now	
❑	❑	Difficult/painful urination
❑	❑	Urgent urination
❑	❑	Burning urination
❑	❑	Incomplete/dribbling urination
❑	❑	Frequent daytime urination
❑	❑	Frequent nighttime urination
❑	❑	Cloudy urine
❑	❑	Blood in urine
❑	❑	Dark yellow/orange urine
❑	❑	Clear /pale urine
❑	❑	Urinary tract infections
❑	❑	Bladder/Kidney Infection
❑	❑	Kidney stones
❑	❑	Increased libido
❑	❑	Decreased libido
❑	❑	Other_____

Psychological

Past	Now	
❑	❑	Depression (mild, moderate, or severe?)
❑	❑	Anxiety/Nervousness
❑	❑	Over-thinking/worry
❑	❑	Panic attacks
❑	❑	Tend toward anger/irritability
❑	❑	Cry frequently for little reason
❑	❑	Mental restlessness
❑	❑	Mental confusion/trouble concentrating
❑	❑	Poor memory
❑	❑	Vivid dreams
❑	❑	Insomnia
❑	❑	Suicidal thoughts
❑	❑	Phobias/Fears _____
❑	❑	Other_____

Patient Name_____

Males

Past	Now	
❑	❑	Enlarged prostate
❑	❑	Erectile dysfunction
❑	❑	Pain in testicles/genitals
❑	❑	Premature ejaculation
❑	❑	Nocturnal emission
❑	❑	Genital discharge
❑	❑	Other_____

Females (If you have already gone through menopause, please answer regarding your past periods)

#Pregnancies_____ # Live Births_____ # Miscarriages_____ # Abortions_____

Did you breastfeed? ❑Yes ❑No How long?_____

Past	Now		Past	Now	
❑	❑	Painful periods	❑	❑	Breast lump/nodules
❑	❑	Irregular periods	❑	❑	Headaches with menses
❑	❑	Abnormal uterine bleeding	❑	❑	Fatigue with menses
❑	❑	Pre-menstrual syndrome	❑	❑	Infertility
❑	❑	Fibroids-How many_____ Size_____	❑	❑	Yeast infections
❑	❑	Endometriosis	❑	❑	Vaginal itching
❑	❑	Painful, swollen breasts-Before/during/after menses	❑	❑	Vaginal discharge –Color_____ Strong odor? ❑Yes ❑ No
			❑	❑	Other

Menstruation:

Age of first period_____ #of days between periods_____ # of days of flow_____

Bleeding is: ❑Heavy ❑Light ❑Bright red ❑Brownish-red ❑Dark red ❑Clots ❑Mucus

Start date of last menses _____ ANY possibility you are pregnant? _____

Please describe any PMS symptoms _____

Menopause: Age of onset_____ Symptoms _____

Patient Name_____

Pain Questionaire

How would you describe your pain?:

❑Dull ❑Achy ❑Sharp/Stabbing ❑Burning ❑Tingling ❑Shooting ❑Deep pain ❑Better with rest ❑Worse with rest/nighttime

What is your pain level? Low 1 2 3 4 5 6 7 8 9 10 High

Please indicate your area(s) of pain: