South Windsor Neck and Back, LLC
Relief today…function for life!

Andrew Gregory, DC, DACNB
Rosanne M. Gregory, DC

During your first visit or consultation, I hope to understand your health concerns, answer questions you may have and give you an examination or consultation using the Oriental medicine approach. Then we will review the results together and look at options available for treatment of your condition. If you elect to undertake treatment, we will begin as soon as possible. Treatment often begins at one's first visit. Your treatment with us is meant to compliment and not replace your regular visits to your Primary Care Practitioner or traditional Western (allopathic) medicine.

This is a **confidential** questionnaire to help us determine the best treatment plan for you. Please fill it out as completely as possible even if you do not feel certain questions pertain to your present condition. Thank you.

Personal Information

Name: ____ Age: ___________ Date: _____________________________

Home Address: ________________________________ City: __________________ State: _____ Zip: ______________

Home Phone: _____________________ Work phone: _____________________ E-mail: _________________________

Birth date: __________________If under 18, person responsible for your account: ______________________________

Emergency Contact Name: ___________________________ Emergency contact phone: __________________________

Whom should we thank for referring you to the office? ____

Have you had acupuncture therapy before? __________If yes, with whom? ____________________________________

Please indicate if any of the following pertain to you: (marking "yes" does not make you ineligible for treatment, however, it may restrict some of our treatment modalities):

☐Hepatitis ☐HIV ☐High Blood Pressure ☐Seizures ☐Pacemaker ☐Blood-thinning meds ☐Pregnancy (certain or possible)

Please indicate the use and frequency of the following:

Coffee: __________________________ Soda: ________________________ Water: ______________________________

Alcohol: _________________________ Tobacco: ______________________ Recreational Drugs: ___________________

Please list any prescriptions, vitamins, supplements and/or over-the-counter medication you are currently taking:

Medication	Reason

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Health History

What are the health issues you are seeking treatment for today? ____

____

____

How long have you had this condition? ____

What other forms of treatment have you sought? ____

____

What helps your condition? ____

What aggravates your condition? ____

Please list any surgeries or major health incidents (accidents, etc.) in your life: ______________________________

____

____

What would you like to achieve with acupuncture? ____

____

Pain Patients; please indicate on the figures below, the areas of the body you experience your pain:

Numbness	Pins & Needles	Burning	Aching	Stabbing
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Front

Back

pain drawing

How would you characterize your pain?

☐Dull / achy ☐Sharp/stabbing ☐burning ☐tingling ☐numbness ☐electrical

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Symptom Survey

Please "check" the symptoms or conditions you experience frequently:

Sp/St	**Ht/P**	**Lu/LI**	**Ki/UB**	**Liv/GB**
__Excessive appetite	__insomnia	__cough	__low back pain	__eye problems
__Loose stool/ diarrhea	__ palpitations	__shortness of breath	__knee problems	__ jaundice
__ Digestive problems/ indigestion	__ cold hands/feet	__ decrease in smell	__ hearing impairment	__ difficulty digesting oily foods
__ Vomiting	__ nightmares	__ nasal problems	__ear ringing	__gall stones
__ Belching/ Burping	__ mentally restless	__ Skin problems	__ kidney stones	__ light-colored stool
__ Heartburn/ Reflux	__ laugh for no reason	__ claustrophobia	__ ↓ sex drive	__ soft/brittle nails
__ Stomach Bloating	__ chest pains	__ colitis/ diverticulitis	__ hair loss	__ anger easily
__ Obsession in work/ relationships	__ poor memory	__ constipation	__ urinary problems	__difficulty w/ decision-making
__ Lack of appetite	__ sadness	__ blood in stool	__ easily bruise	
__ Hemorrhoids	__ dental problems	__ high cholesterol		
__Recent use of antibiotics		__ bitter taste		

Etc

__ fatigue	__ edema	__ asthma	__ allergies	__ dizziness
__ get sick easily	__ headaches	__ I usually feel warm	__ I usually feel chilled	

Are you interested in additional health services besides acupuncture? ☐No ☐Yes

Please check which services you might be interested in: ☐ Chiropractic Services ☐ Chinese herbal medicine

☐ Relaxation Techniques ☐ Nutritional Consultation

Please indicate if any of the following pertain to you:
NOTE: the symbol ♀ indicates the question pertains to WOMEN ONLY

Kidney Yin Xu-

☐ Do you have lower back weakness, soreness or pain?

☐ Do you have ringing in your ears?

☐ Is your hair prematurely gray?

☐ Do you have dark circles under your eyes?

☐ Do you have night sweats

☐ Are you prone to hot flashes?

☐ Would you describe yourself as “afraid” frequently?

☐ Do you have dizziness?

☐ Do you have knee problems?

☐♀ Do you have vaginal dryness?

☐♀ Is your mid-cycle cervical mucus scarce or missing?

Kid Yang Xu-

☐ Is your back sore or weak?

☐ Are your feet cold, especially at night?

☐ Are you typically colder than those around you?

☐ Is your libido low?

☐ Are you often fearful?

☐ Do you wake up at night or early in the morning because you have to urinate?

☐ Do you urinate frequently, and is the urine diluted and/or profuse?

☐ Do you have early morning, loose, urgent stools?

☐♀ Premenstrually, do you have low back pain?

☐♀ Do you have profuse vaginal discharge?

☐♀ Do you feel cold cramps during your period that respond well to a heating pad?

Spleen Qi- Xue- Yang Xu

☐ Are you often fatigued?

☐ Do you have poor appetite?

☐ Is your energy low after a meal?

☐ Do you feel bloated after eating?

☐ Do you crave sweets?

☐ Do you have loose stools, abdominal pain or digestive problems?

☐ Are your hands and feet cold?

☐ Are you prone to feeling sluggish?

☐ Are you prone to heaviness/ grogginess in the head?

☐ Do you have varicose veins?

☐ Are you prone to worry?

☐ Have you been diagnosed with low blood pressure?

☐ Do you sweat a lot without exerting yourself?

☐ Do you feel dizzy or light headed, or have visual changes when you stand up fast?

☐ Do you have allergies or are you sick often?

☐ Have you ever been diagnosed with hypothyroid or anemia?

☐ Do you have hemorrhoids or polyps?

☐♀ Is your menstruation thin, watery, profuse or pinkish in color?

☐♀ Are you more tired around ovulation or menstruation?

☐♀ Do you ever spot a few days or more before your period comes?

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☐♀ have you ever been diagnosed with a uterine prolepses?

☐♀ Are your menstrual cramps accompanied by a bearing down sensation in your uterus?

Blood Xu-

☐ Do you have dry, flaky skin?

☐ Are you prone to getting chapped lips?

☐ Are your finger or toenails brittle?

☐ Is your hair dry or brittle?

☐ Do you have diminished nighttime vision?

☐ Are your lips, the inner side of your eyelids, or tongue pale in color?

☐♀ Do you get dizzy or light-headed around your period?

☐♀ Are you losing hair on your head?

☐♀ Is your menstruation scant or late?

Blood Stasis

☐ Do you experience periodic numbness of your hands and feet, especially at night?

☐ Do you have varicose/ spider veins?

☐ Do you have red cherry spots (hemangiomas) on your skin?

☐ Do you have chronic hemorrhoids?

☐ Do you have dark spots in your eyes?

☐ Have you been diagnosed with any vascular abnormality or blood clotting disorder?

☐♀ Does your menstrual blood contain clots?

☐♀ Have you been diagnosed with endometriosis or uterine fibroids?

☐♀ Do you have piercing or stabbing menstrual cramps?

☐♀ Is your menstrual flow ever black or brown in color?

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☐♀ Do you have mid-cycle pain around your ovaries?

☐♀ Do you have painful, unmovable breast lumps?

Liver Qi Stagnation

☐ Are you prone to emotional depression?

☐ Are you prone to anger/ rage?

☐ Are your pupils dilated and/or large?

☐ Do you have difficulty falling asleep at night?

☐ Do you experience heartburn or wake up with a bitter taste in your mouth?

☐♀ Do you become irritable pre-menstrually?

☐♀ Do you feel bloated or irritable around ovulation?

☐♀ Does it feel as if your ovulation lasts longer than it should?

☐♀ Are your breasts sensitive/sore at ovulation?

☐♀ Do you experience nipple pain or discharge from your nipples?

☐♀ Do you have a lot of pre-menstrual breast swelling or pain?

☐♀ Are you usually bloated before your menstruation?

☐♀ Are your menses painful?

☐♀ Do you feel your menstrual cramps in the external genital area?

☐♀ Is your menstrual blood thick and dark, or purplish in color?

Heart

☐ Do you wake up early in the morning and have trouble getting back to sleep?

☐ Do you have heart palpitations, especially when anxious?

☐ Do you have nightmares?

☐ Do you seem low in spirit or lacking vitality?

- ☐ Are you prone to agitation or extreme restlessness?
- ☐ Do you fidget?
- ☐ Do you sweat excessively, especially on your chest?

Excess Heat

- ☐ Are your mouth and throat usually dry?
- ☐ Are you often thirsty for cold drinks?
- ☐ Do you often feel warmer than those around you?
- ☐ Do you wake up sweating or have hot flashes?
- ☐♀ Do you break out with red acne, especially pre-menstrually?
- ☐♀ Do you have a short menstrual cycle?
- ☐♀ Do you have vaginal irritation?

Dampness

- ☐ Do you feel tired and sluggish after a meal?
- ☐ Do you have cystic or pustular acne?
- ☐ Do you have urgent, bright, or foul-smelling stools?
- ☐ Are you overweight?
- ☐ Do you have a wet, slimy tongue?
- ☐ Does your body feel like a barometer? Can you sense when it will rain?
- ☐♀ Does your menstrual blood contain stringy tissue or mucus?
- ☐♀ Are you prone to yeast infections and vaginal itching?
- ☐♀ Do you have fibrocystic breasts?