Dragonfly Acupuncture

Client Information

Date _____

Personal Information

Name		Please address me as	
Address			
City	State	Zip	Preferred contact method ☐ Call ☐ Text ☐ Email ☐ Post
Phone		May we leave voicemail at this number? ☐ Yes ☐ No	
Email		Occupation	
Birth Date	Age	Sex	Gender Identity

Military Information (if applicable)

☐ Military veteran ☐ Currently serving	Branch	Dates of Service
Military Specialty	Were you deployed to a combat location?	

Emergency Contact Information

Name	Phone	Relationship

Referral Information

How did you hear about us?

General Information

Have you had acupuncture before?

What is the main reason(s) you are seeking treatment?

Dragonfly Acupuncture

Client Checklist

Your treatment is based on the information you provide. In the sections below, check anything that applies to you. All of your answers are CONFIDENTIAL.

Energy/Temperature
- ☐ tired or fatigued
- ☐ generally cold
- ☐ cold hands and feet
- ☐ perspire easily
- ☐ low grade fevers
- ☐ generally hot
- ☐ chills
- ☐ perspire at night

Other/Info:

Sleep
- ☐ vivid dreams
- ☐ nightmares
- ☐ sleepwalking
- ☐ difficulty falling asleep
- ☐ difficulty staying asleep
- ☐ difficulty waking up

Other/Info:

Taste/Thirst/Digestion
- ☐ abdominal pain
- ☐ gas
- ☐ vomiting
- ☐ heartburn
- ☐ always hungry
- ☐ always thirsty
- ☐ bloating
- ☐ nausea
- ☐ ulcers
- ☐ acid reflux
- ☐ rarely hungry
- ☐ rarely thirsty
- ☐ drink a certain amount of fluids each day

Other/Info/Food or flavor cravings:

Urine & Stools

Urine:
- ☐ scanty
- ☐ dribbling
- ☐ burning
- ☐ has sand or stones
- ☐ frequent
- ☐ profuse
- ☐ painful
- ☐ bloody
- ☐ incontinent

I wake at night to urinate_____ (#) of times

Stools:
- ☐ formed
- ☐ constipation
- ☐ blood in my stools
- ☐ rectal bleeding
- ☐ loose
- ☐ hard or pebbly
- ☐ diarrhea
- ☐ mucus in my stools
- ☐ hemorrhoids

Other/Info:

Eyes
- ☐ blurred vision
- ☐ cataracts
- ☐ "floaters"
- ☐ redness
- ☐ glaucoma
- ☐ dryness

Other/Info:

Ears
- ☐ difficulty hearing
- ☐ vertigo
- ☐ dizziness
- ☐ ear ringing or buzzing
- ☐ frequent ear infections

Other/Info:

Respiratory
- ☐ asthma
- ☐ congestion
- ☐ frequent colds
- ☐ shortness of breath
- ☐ COPD
- ☐ nosebleeds
- ☐ bronchitis
- ☐ cough
- ☐ nasal discharge
- ☐ sinusitis
- ☐ emphysema
- ☐ frequent sinus infections

Other/Info:

Cardiovascular
- ☐ chest pain
- ☐ heart attack
- ☐ irregular heart beat
- ☐ pacemaker
- ☐ chest tightness
- ☐ high blood pressure
- ☐ palpitations

Other/Info:

Skin
- ☐ acne
- ☐ itching
- ☐ eczema
- ☐ psoriasis
- ☐ hives
- ☐ rashes

Other/Info:

Allergies
- ☐ seasonal
- ☐ foods
- ☐ medications
- ☐ environmental
- ☐ animals
- ☐ materials (wool, latex, etc.)

Other/Info:

Lifestyle
- ☐ drink alcohol
- ☐ drink tea
- ☐ drink coffee
- ☐ vegetarian/vegan
- ☐ use recreational drugs
- ☐ drink caffeinated beverages
- ☐ smoke/chew tobacco
- ☐ use "energy" products
- ☐ religious or other dietary restrictions

Other/Info:

Miscellaneous

I have or have had in the past:
- ☐ diabetes
- ☐ thyroid problems
- ☐ liver problems
- ☐ immune disorder
- ☐ cancer
- ☐ bleeding disorder
- ☐ HIV/AIDS
- ☐ seizures
- ☐ kidney problems
- ☐ psychiatric condition
- ☐ PTSD
- ☐ eating disorder
- ☐ stroke

Other/Info:

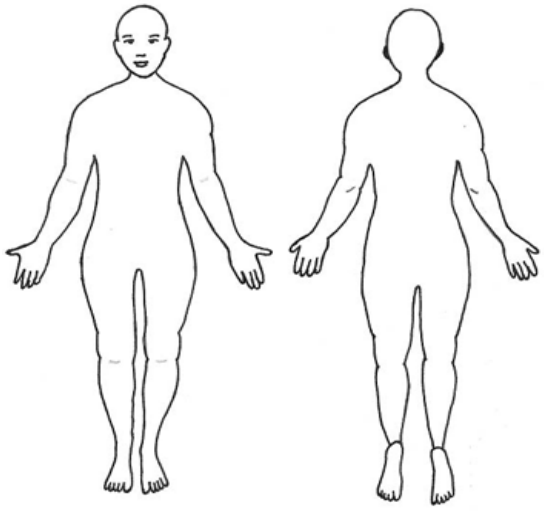
Women Only
□currently pregnant □trying to get pregnant
At what age did you start menstruating? _____
Stop menstruating (if applicable)? _____
Number of days in cycle _____
□regular □irregular □long □short
Number of days of menstrual flow _____
□heavy □light □spotty □ clots
What color is the blood? _____
□painful periods □cramps □headaches
□vaginal discharge □fibroids □cysts
□endometriosis □infertility
I have had (#) _____ pregnancies _____ births
_____ miscarriages _____ terminations
Other/Info:

Men Only
□testicular pain □impotence
□prostate problems □decreased sex drive
Other/Info:

Exercise/Activity
Number of days per week you exercise _____
Total time per day you exercise _____
Types of activities:

Musculoskeletal/Pain
□joint pain □joint dysfunction
□muscular pain □stiffness
□swelling □weakness
□paralysis □numbness/tingling
□arthritis □migraines
□headaches □tremors
□phantom limb syndrome
Other/Info:

Please indicate the location(s) of your pain on the chart:



Well-Being
Check any of the following that you have experienced in the last 6 months *or that are a concern to you*:

- □ Anger / Irritability
- □ Apathy / Loss of interest
- □ Avoidance of people or places
- □ Constant fatigue
- □ Cynicism or negativism
- □ Difficulty concentrating
- □ Difficulty remembering incident(s)
- □ Exaggerated startle response
- □ Feeling “numb” or “detached”
- □ Feeling always “on guard”
- □ Feeling separated from your body or surroundings
- □ Feeling the world no longer makes sense
- □ Feeling guilty
- □ Feeling anxious
- □ Feeling overwhelmed
- □ Flashbacks or intrusive memories
- □ Hostility or violent behavior
- □ Increased use of alcohol, tobacco
- □ Increased use of medications or drugs
- □ Nightmares
- □ Questioning religious or spiritual values
- □ Sadness or depression
- □ Withdrawal from usual activities
- □ Other:

What are the main factors that cause stress for you?

What do you do to take care of yourself?

Additional Information
Please list any surgeries, hospitalizations and/or significant injuries:

Please list all medications you are taking, including birth control, vitamins, and supplements:

Name	Dose	Reason	How Long	Recommended By

Is there anything else you would like me to know in order to best serve your health care needs?
(Of course, you may bring up new symptoms/concerns at any time.)