Matthew Stampe, LAc,
Licensed Acupuncturist

This is a CONFIDENTIAL questionnaire to help determine the best treatment plan for you

Name_____ Date_____

Home Address_____ City_____

State_____ Zip_____ Home Phone_____ Work_____

Occupation_____ Person Responsible for your account_____

Emergency Contact_____ Phone_____

Who can we thank for referring you?_____

Sex___ M___F Height_____ Weight_____ Birth date_____ Age_____

Marital Status □ Married □ Single □ Divorced □ Widowed Number of Children_____

Previous Acupuncture? □ yes □ no When?_____ With Whom_____

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

Illness	You	Relative	When?	Illness	You	Relative	When?
Cancer	□	□	_____	Diabetes	□	□	_____
Hepatitis	□	□	_____	Heart Disease	□	□	_____
High blood pressure	□	□	_____	Seizures	□	□	_____
Rheumatic Fever	□	□	_____	Emotional disorders	□	□	_____
Infectious Disease	□	□	_____	Tuberculosis	□	□	_____

Sexually Transmitted disease: □ gonorrhea □ syphilis □ HIV □ HPV □ chlamydia □ herpes Date: _____

Please indicate the use and frequency of the following:

	Yes	No	Amount		Yes	No	Amount		Yes	No	Amount
Coffee/black tea	□	□	_____	Tobacco	□	□	_____	Water intake	□	□	_____
Recreational drugs	□	□	_____	Alcohol	□	□	_____	Soda Pop	□	□	_____

Please check the box if any of the following statements are true:

I have known allergies □ I am taking Coumadin / Warfarin □

I have a pacemaker □ I am taking lithium (Eskalith, Lithobid, Lithonate, Lithotabs) □

List any medications and supplements you are currently taking: (continue on the back if needed)

Medicine	Dosage	Reason	How Long	Prescribed by	Date last checkup

For Women

Age of 1st period (menarche)_____ Are you pregnant? □Yes □ No # of pregnancies_____

Age of last period (menopause)_____ # of live births_____ # of abortions_____ # of miscarriages_____
Number of days between periods_____ Date of last gynecological exam_____ Pap smear_____
Number of days of flow_____ Mammogram_____ Bone density scan_____
Color of flow_____ Results_____
Clots? □ Yes □ No Color_____ _____
Average number of pads you use per day: 1st day_____ 2nd day_____ 3rd day_____ 4th day_____ +days_____
Have you been diagnosed with: □ Fibroids □ Fibrocystic Breasts □ Endometriosis □ Ovarian Cysts □ PID Other_____
Location of Pain: □ Lower abdomen □ Lower back □ Thighs □ Other_____
Nature of pain: (please indicate before, during or after menses) Other symptoms related to menses

Cramping_____	Stabbing_____	□ Discharge	□ Vaginal dryness	□ Headache
Burning_____	Aching_____	□ Nausea	□ Constipation	□ Diarrhea
Dull_____	Bloating_____	□ Swollen breasts	□ Mood swings	□ Ravenous appetite
Consistent_____	Intermittent_____	□ Poor Appetite	□ Hot flashes	□ Night sweats
Bearing down sensation_____		□ Increased libido	□ Decreased libido	□ Insomnia

For Men

Date of last prostate check up_____ PSA results_____ Manual prostate exam results_____
Lab results_____
Frequency of urination: daytime_____ night time_____ Color of urine: □ clear □ murky odor:_____
Symptoms related to prostate

□ Prostate problems	□ Delayed stream	□ Dribbling	□ Incontinence	□ Retention of urine
□ Rectal dysfunction	□ Increased libido	□ Decreased libido	□ Premature ejaculation	□ Impotence
□ Back pain	□ Groin pain	□ Testicular pain	Other_____	

Please circle if any of these are affecting you

Poor appetite	Shortness of breath	Lower back pain	Irritability	Heart Palpitations
Tired	Wheezing	Weak knees	Pain on sides of body	Chest pain
Fatigued	Cough	Edema in Legs	Moody/Angry	Cold hands
Loose Stools	Weak Voice	Impotence	Vertigo	Speech issues
Feeling Heavy	Dry mouth	Decreased libido	Headaches	Confusion
Indigestion	Dry throat	Poor memory	PMS	Insomnia
Nausea	Sneezing	Urinary issues	Disturbed dreams	Rapid Breathing
Constipation	Abdominal pain	Cold limbs	Indecisive	Heavy period
Epigastric pain	Diarrhea	Sweaty hands and feet	High pitch ear ringing	Mania/easily excited
Vomiting	Dry stools	Dizziness	Muscle cramps	Restlessness
Hiccup	Hemmeroid	Amenorrhea	Muscle spasms	Thirsty
Burping	Grief	Infertility	Tremors	Mouth ulcers
Weak Muscles	Sadness	Fearful	Hypertension	Spontaneous sweating
Worry	Chest oppression	Achy bones	Depression	Difficult breathing
Pensive	Skin problems	Low pitch ear ringing	Bitter taste in mouth	Light headed

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

_____

_____

Which other forms of treatment have you sought? _____

_____

_____

List any other health problems you now have

_____

_____

_____

_____

List any allergies, food sensitivities or food craving that you have. _____

_____

_____

_____

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

_____

_____

_____

_____

Lab Results: (please include copies)_____

_____

_____

Clinical Notes

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

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

Patient Pain Drawing

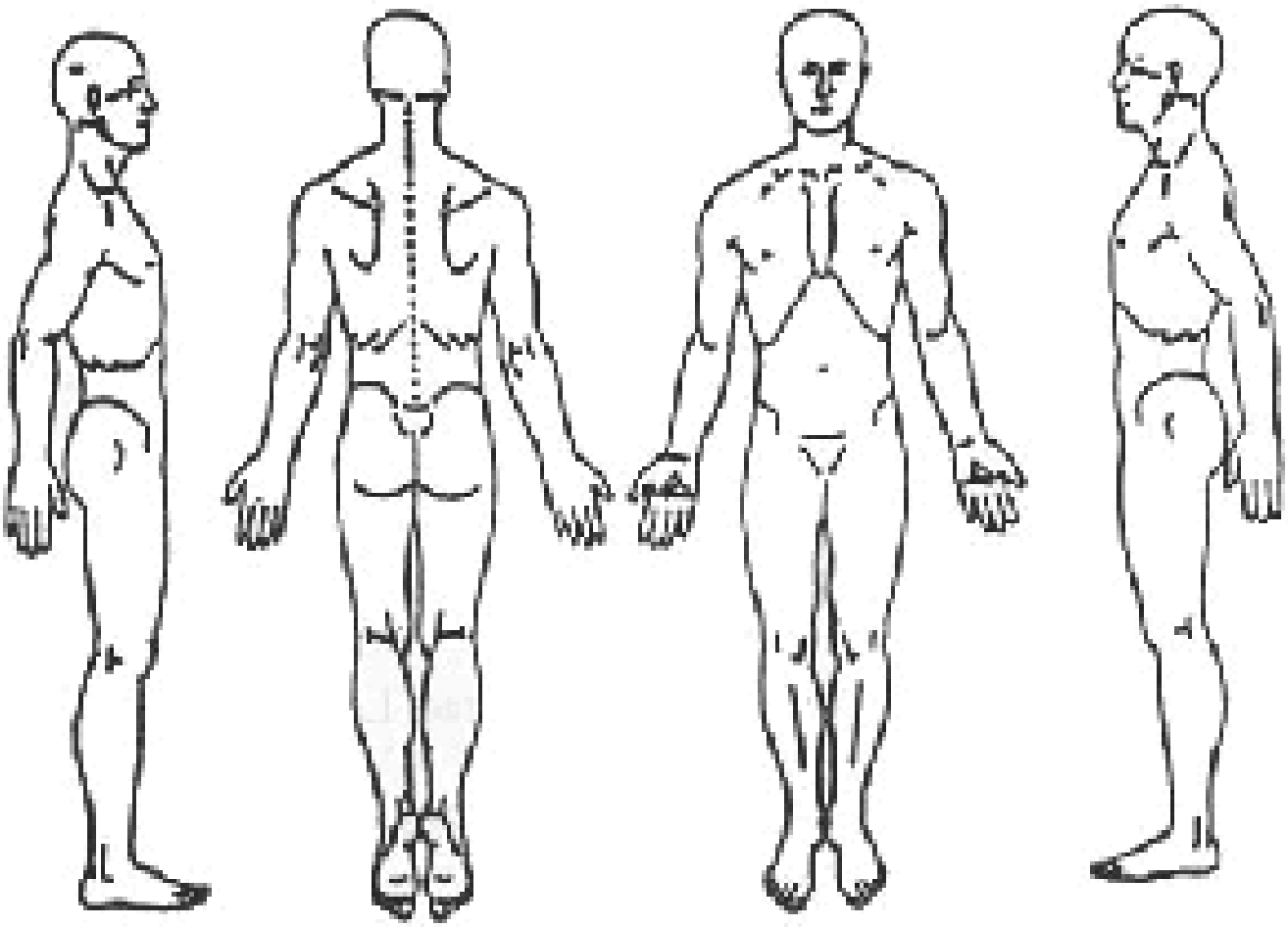
Patient Name_____ **Date:**_____

Mark the areas on your body where you feel the described sensations. Use the appropriate symbol. Include all affected areas.

Ache	**Numbness**	**Pins & needles**	**Burning**	**Stabbing**
ΔΔΔΔΔ	======	OOOOOO	XXXXXX	///////

Back **Front**

Pain in arms compared to neck
□ worse than
□ same as
□ less than



Pain in leg(s) compared to neck
□ worse than
□ same as
□ less than