

Please use the tab key or your cursor to move from line to line.

DESCRIBE HOW AND WHEN YOUR MAIN COMPLAINT DEVELOPED: _____

HAVE YOU EXPERIENCED THIS BEFORE? WHEN? _____

DID YOU EVER RECEIVE TREATMENT FOR THIS? WHEN? _____

WHAT WERE THE RESULTS OF THE TREATMENTS? _____

IS THE CONDITION GETTING WORSE? _____

HOW HAS THE CONDITON AFFECTED YOUR LIFE PHYSICALLY, MENTALLY AND EMOTIONALLY: _____

WHAT IS YOUR STRESS LEVEL ON A SCALE OF 1-10? _____

HOW IS YOUR SLEEP? _____

WOMEN: PLEASE DESCRIBE YOUR MENSTRUAL HISTORY FROM ADOLESCENCE TO PRESENT (please include operations): _____

NUMBER OF PREGNANCIES-NUMBER OF CHILDREN: _____

DO YOU HAVE ANY LONG-TERM ACUPUNCTURE GOALS? _____

PLEASE LIST THE MEDICATIONS YOU ARE TAKING AND WHAT THEY ARE FOR:

- | | |
|---|---|
| 1 | 2 |
| 3 | 4 |
| 5 | 6 |
| 7 | 8 |