NEW PATIENT QUESTIONNAIRE
From the office of Dr. Julia Tortolani
NCCAOM Board Certified & Licensed Acupuncturist

Welcome to Good Point Acupuncture

This is a CONFIDENTIAL questionnaire for new patients. The information provided contributes to the determination of a successful treatment plan for you. We are glad to answer any questions. If you need assistance just ask.

Name: _____ Today's Date: ____/____/_____
(First Name) (Last Name)

Home Address: _____ City: _____

State: _____ Zip: _____ E-Mail: _____
(all caps please)

Phone Numbers: _____ _____ _____
Check Preferred: (Home) □ (Cell) □ (Office) □

Date of Birth: ____/____/_____ Age: _____ Height: _____ Weight: _____

Gender: _____ Pronoun Preference: _____

Emergency Contact: _____ _____
(Name) (phone)

In providing emergency contact information, you acknowledge that this person may be contacted in the event of a medical concern, and information with respect to your health condition may be disclosed. Kindly indicate you're in agreement by writing your initials: _____

Whom may we thank for referring you to this office? _____

Have you received acupuncture before? Yes □ No □ If yes, when? _____

What conditions were treated with acupuncture historically: _____

Who was your acupuncturist(s)? _____

HEALTH CONDITIONS & GOALS:

Please list the health conditions you would like to address with acupuncture and TCM. You may list recent injuries, chronic ailments, formal diagnoses, and suspected conditions. It is great to phrase these as health goals such as to stop headaches, reduce knee pain, improve sleep, reduce stress, and promote well-being:

	Onset Date
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____
5. _____	_____

Please check if any of the following apply:

- ☐ I have a pacemaker
- ☐ I am allergic to metals such as iron, steel, or other metal alloys
- ☐ I am taking Coumadin/Warfarin or similar blood-thinning medication
- ☐ I am taking Lithium (Eskalith, Lithobid, Lithonate, Lithotabs)
- ☐ I take NSAIDs daily (aspirin/ibuprofen/tylenol/naporoxen/diclofenac/etc…) reason: _____

KNOWN ALLERGIES

Please list known allergies to food, medication, or seasonal: Onset

1. _____ _____
2. _____ _____
3. _____ _____

Check if you have frequently taken:

- ☐ Antibiotics
- ☐ Antihistamines
- ☐ Anti-Depressants
- ☐ Vitamins
- ☐ Skin Ointments
- ☐ Bronchial Inhalers
- ☐ Cortisone
- ☐ Nose Drops or Sprays
- ☐ Sedatives/Sleep Aids
- ☐ Hormones
- ☐ Birth Control Pills

Please list medications, vitamins, herbs and homeopathic remedies you currently take. You may use space at bottom of page if necessary:

Name	**Dosage**

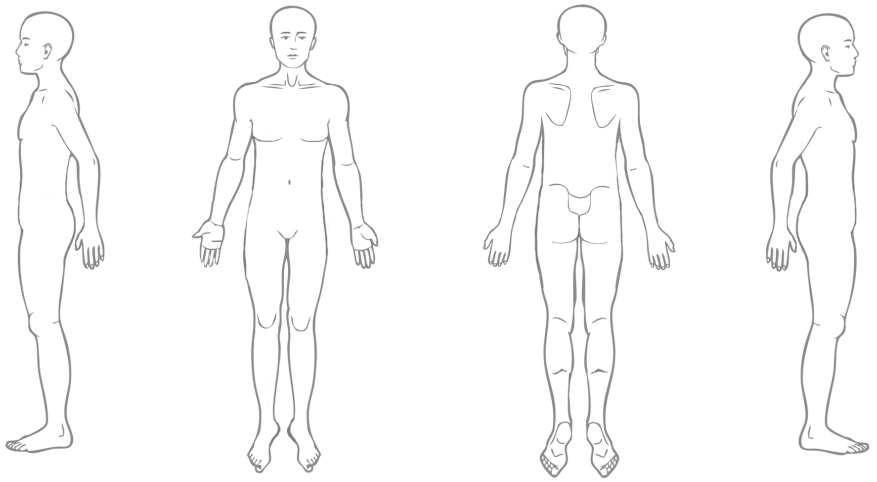
FAMILY HISTORY: Do you have a personal or family history of:

Diabetes:	Self ☐	Family ☐	Hypertension:	Self ☐	Family ☐
Cardio-Vascular Disease:	Self ☐	Family ☐	Tuberculosis:	Self ☐	Family ☐
Allergies:	Self ☐	Family ☐	Rheumatic Fever:	Self ☐	Family ☐
Asthma:	Self ☐	Family ☐	Seizures:	Self ☐	Family ☐
Cancer:	Self ☐	Family ☐	Hepatitis:	Self ☐	Family ☐
Alcoholism	Self ☐	Family ☐	Thyroid Disorder	Self ☐	Family ☐

HOSPITALIZATIONS: Have you ever been hospitalized for a:

Medical problem:	No ☐	Yes ☐	_____
Surgical procedure:	No ☐	Yes ☐	_____
Psychiatric reason:	No ☐	Yes ☐	_____

Please indicate if there are certain physical areas you would like to concentrate on healing.



LEFT **FRONT** **BACK** **RIGHT**

You may use this space to expand on any known conditions contributing to your current state of well-being.
For example: Working long hours or night shifts, prolonged sitting, injuries or accidents, etc.

_____

_____

LIFESTYLE

Please indicate which of the following are a part of your lifestyle
and how frequently you engage in it: *(Example: 2x/day, 5x/week, 3x/month, etc.)*

Meditation No□ Yes□: ___x/____
Exercise: No□ Yes□: ___x/____
Cannabis: No□ Yes□: ___x/____
Alcohol: No□ Yes□: ___x/____

Coffee: No□ Yes□: ___x/____
Other Caffeine: No□ Yes□: ___x/____
Nicotine: No□ Yes□: ___x/____
Excessive Sugar: No□ Yes□: ___x/____

How many meals do you generally eat per day? ___

Do you follow any particular diet? No □ Yes □: If yes, please describe: _____

STRESS

On the scale of 1-10, how would you rate your level of daily stress: _____

How does stress affect you? _____
(i.e., stomach aches, insomnia, tension headaches, digestive issues, irritability, etc.)

URINATION: Please check any of the following symptoms you currently experience:

☐ No Symptoms
☐ Burning
☐ Urgency
☐ Retention
☐ Scanty
☐ Profuse
☐ Dribbling
☐ Urination frequency greater than 1x per night
Frequency: ____ /night

LOWER DIGESTION & **BOWEL MOVEMENTS**:

Typical number of bowel movements per day: _____

Time of day: ☐Upon Waking ☐AM ☐After AM Coffee ☐Afternoon ☐Evening ☐Night-time

Consistency of my stool tends toward: ☐Well-formed ☐Hard ☐Loose ☐Diarrhea

Do you regularly experience: ☐Constipation ☐Urgency ☐Both ☐Cramping ☐Abdominal Dissension

Have you noticed your stool contains:
☐ Undigested food
☐ Blood
☐ Mucus
☐ Alternates Hard/Loose
☐ Other: _____

Have you been diagnosed with IBS? ☐Yes ☐No

Do you have any other lower GI concerns? ☐Yes ☐No _____

SLEEP:

Average number of hours of sleep per night: _____ *Do you feel rested after sleep ☐No ☐Yes

Do you generally wake up quickly? ☐Yes ☐No, I am slow to rise

Upon Waking:

Face is puffy	☐Yes	☐No
Dry Eyes	☐Yes	☐No
Thirsty	☐Yes	☐No

Do you regularly experience nightly sleep interruptions? ☐Yes ☐No

My **external** causes of sleep interruptions are: _____
(children, bed partner, dog, environmental noise, etc…)

My **internal** causes of sleep interruption are: _____
(body pain, wake to urinate, active mind, stress, my dreams wake me, etc…)

Please select the appropriate box based on this numbering system:

0 = Never 1 = Rarely 2 = Occasionally 3 = Frequently 4 = Always

0□	1□	2□	3□	4□	low appetite	0□	1□	2□	3□	4□	ravenous appetite
0□	1□	2□	3□	4□	loose stools	0□	1□	2□	3□	4□	heartburn/acid reflux
0□	1□	2□	3□	4□	mouth sores	0□	1□	2□	3□	4□	fatigue after eating
0□	1□	2□	3□	4□	gas/bloating after food	0□	1□	2□	3□	4□	bruise easily
0□	1□	2□	3□	4□	gums (bleeding/swollen)	0□	1□	2□	3□	4□	thirst
0□	1□	2□	3□	4□	organ prolapse (diagnosed)	0□	1□	2□	3□	4□	belching or vomiting

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0□	1□	2□	3□	4□	spontaneous sweating	0□	1□	2□	3□	4□	fatigue
0□	1□	2□	3□	4□	allergies	0□	1□	2□	3□	4□	catch colds easily
0□	1□	2□	3□	4□	asthma	0□	1□	2□	3□	4□	shortness of breath
0□	1□	2□	3□	4□	general weakness	0□	1□	2□	3□	4□	cough
0□	1□	2□	3□	4□	dry nose/mouth/skin/throat	0□	1□	2□	3□	4□	nasal discharge
0□	1□	2□	3□	4□	feel worse after exercise	0□	1□	2□	3□	4□	sinus congestion

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0□	1□	2□	3□	4□	sore, cold or weak knee	0□	1□	2□	3□	4□	feel cold
0□	1□	2□	3□	4□	low back pain	0□	1□	2□	3□	4□	edema
0□	1□	2□	3□	4□	frequent urination	0□	1□	2□	3□	4□	urinary incontinence
0□	1□	2□	3□	4□	early morning diarrhea	0□	1□	2□	3□	4□	ear problems

Impaired memory: yes □ no □ Hair loss: yes □ no □
Infertility: yes □ no □ Libido: high □ normal □ low □

0□	1□	2□	3□	4□	muscle spasms/twitches	0□	1□	2□	3□	4□	irritable
0□	1□	2□	3□	4□	feel better after exercise	0□	1□	2□	3□	4□	numb extremities
0□	1□	2□	3□	4□	tight feeling in chest	0□	1□	2□	3□	4□	dry eyes
0□	1□	2□	3□	4□	alternating diarrhea/constipation	0□	1□	2□	3□	4□	ear ringing
0□	1□	2□	3□	4□	symptoms worse with stress	0□	1□	2□	3□	4□	angers easily
0□	1□	2□	3□	4□	neck/shoulder tension	0□	1□	2□	3□	4□	red eyes

0□	1□	2□	3□	4□	feel pronounced heart beating	0□	1□	2□	3□	4□	chest pain
0□	1□	2□	3□	4□	insomnia	0□	1□	2□	3□	4□	disturbing dreams
0□	1□	2□	3□	4□	sores on tip of tongue	0□	1□	2□	3□	4□	headaches
0□	1□	2□	3□	4□	anxiety	0□	1□	2□	3□	4□	restlessness
0□	1□	2□	3□	4□	chest pain traveling to shoulder						

Body Temperature I run hot□ generally comfortable□ I tend towards being cold □
Overall energy level high energy□ constant energy throughout the day□ low/fatigued daily □

0□	1□	2□	3□	4□	see floaters in my eyes	0□	1□	2□	3□	4□	foggy thinking
0□	1□	2□	3□	4□	heat in palms or soles	0□	1□	2□	3□	4□	dizzy upon standing
0□	1□	2□	3□	4□	feeling of heaviness	0□	1□	2□	3□	4□	nausea
0□	1□	2□	3□	4□	afternoon fever	0□	1□	2□	3□	4□	night sweats
0□	1□	2□	3□	4□	enlarged lymph nodes	0□	1□	2□	3□	4□	cloudy urine
0□	1□	2□	3□	4□	face flushes						

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People with **Female Reproductive Anatomy** if you feel comfortable doing so, please complete this section.

….everyone else, please skip to page 9

MENSTRUAL HISTORY

The menstrual cycle reflects one's overall health and provides a wonderful window into one's well-being. If you are comfortable answering these questions about your menstrual cycle please take a moment to do so, they can really inform your treatment and which acupuncture points will be most efficient and effective.

1. At what age did you get your first menstrual period? _____
2. Are you presently still getting a menstrual cycle? Yes□ No□

Patients who are still menstruating:

Approximately what day did your most recent menstrual cycle begin: ____/____

Are you currently taking oral contraceptives (the pill) No□ Yes□
Are you currently taking any hormone therapy? No□ Yes□
Are you utilizing another medical birth control therapy? No□ Yes□ _____

Number of days from the start of one period to the start of the next: _____ (28, 36, 40…)

Are your menstrual cycles spaced regularly? No□ Yes□ Number of flow days: _____
Use of tampon or pad is:
□ Light = use one for longer than 4 hours
□ Moderate = change every 2-3 hours
□ Heavy = change every hour or less

On maximum flow day, blood color is: Pink□ Red□ Dark□ Bright-Red□ Brown□
Are there clots present? No□ Yes□
Does your period cause pain or cramping? No□ Yes □: If yes: Before□ During□ After Period□
Nausea or Vomiting with your period? No□ Yes□: If yes: Before□ During□ After Period□

Do you experience any of the following before your period each month?
□ Heightened Emotional Awareness □ Feel Blue □ Water Retention □ Breast Tenderness/Swelling
□ Low Energy □ Irritability □ Migraines
□ Food Cravings (sugar, caffeine, chocolate, salt?) _____

Do you ever bleed or spot between periods? Yes □ No □
Do you have any *atypical* vaginal discharge between periods? Yes □ No □

GYNECOLOGICAL BACKGROUND

Do you see a gynecologist regularly Yes □ No □ (no judgement either way)
Do you have any gynecological concerns Yes □ No □
Do you get yeast infections regularly? Yes □ No □
Have you ever been diagnosed with:
□ Uterine fibroids or polyps □ Ovarian cysts or PCOS
□ Endometriosis □ Pelvic adhesion abnormalities

MENOPAUSE

Have you experienced menopause or peri-menopause? Yes □ No □ **If no, skip this section**

If Yes, when did you start menopause? _____

Are you on HRT (hormone replacement therapy) or herbal aids now? Yes □ No □

If you are experiencing any of the following menopausal signs or symptoms, please indicate below:

□Night Sweats
□Hot Flashes
□Vaginal Dryness
□Increased Vaginal Lubrication
□Increased Libido
□Decreased Libido
□Dryness of skin, hair, or eyes
□Increased thirst
□Increased courage, bravery, boldness
□Irritability
□Early waking with no negative side effects
□Change in sleep requirements (need less sleep?)
□Improved clarity of purpose
□Foggy head
□Feeling more confident about my appearance
□Improved opinion of yourself and your abilities
□Reduced body fat

□other observations:_____

FERTILITY

Is fertility something you would like to address with acupuncture?

□Yes □No, not at this time. **If no, skip this section**

* **If yes,** please complete the following questions and we will have a more in-depth conversation about your fertility goals.

FERTILITY HISTORY

1. Are you pregnant now? Yes □ No □ Maybe □
2. Have you ever been pregnant? Yes □ No □
3. Number of Live Births: ____ Miscarriages: ____ Abortions: ____

F**ertility workup (if pertinent)**

Doctor or clinic: _____ When? _____

Would you like Dr. Tortolani to correspond with your reproductive specialist? Yes □ No □

We will have a conversation about what tests have been conducted (HSG, hormone levels, blood work) and their findings.
Please list current fertility medications (Clomid, Lupron, Menopur, Gonal F, Ovidrel, HCG, Progesterone, etc.) and treatment plan:

_____

_____

I have provided correct and complete information to the best of my knowledge.

_____ _____ / _____ / _____
Patient Name Patient Date of Birth

_____ _____ / _____ / _____
Patient's Signature Today's Date

People born with **Male Reproductive Anatomy**

Any anatomical diseases/disorders of the male anatomy that you wish to address today? Yes □ No □

If so, please Explain:

_____

_____

I have provided correct and complete information to the best of my knowledge.

_____ _____ / _____ / _____
Patient Name Patient Date of Birth

_____ _____ / _____ / _____
Patient's Signature Today's Date