



Please fill out this CONFIDENTIAL questionnaire to help us determine the best treatment plan for you. Thank you.

**Personal Information**

Name: Age: Birth Date:

Address:

City State: Zip:

Phone number:

E-mail address:

If under 18, person responsible for your account:

Emergency Contact: Name: Contact Phone:

Whom shall I thank for referring you to Nuurvana?

Have you had acupuncture therapy before?  Yes  No

Have you had a clairvoyant intuitive reading before?  Yes  No

**Please indicate if any of the following pertain to you:**

- Hepatitis  HIV  High Blood Pressure  Seizures  Pacemaker
- Blood-Thinning Medication  Pregnancy

**Please indicate how frequently you consume the following:**

Coffee: Soda: Water:

Alcohol: Tobacco:

**Please list any prescription or over-the-counter medications and supplements you are presently taking:**

| Medication / Supplement | Reason | For how long now? |
|-------------------------|--------|-------------------|
|-------------------------|--------|-------------------|

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**Health History**

Please indicate your top 3 health concerns for which you are seeking treatment and how long you have been experiencing them:

- 1. \_\_\_\_\_
- 2. \_\_\_\_\_
- 3. \_\_\_\_\_

What other forms of treatment have you sought?

What helps your condition?

What aggravates your condition?

What would you like to achieve with our intuitive acupuncture sessions?

As we will discuss, your health transformation is a process.

Please include your short-term health goals:

Please include your long-term health goals:

Please indicate your level of commitment to these goals. (How frequently will you be coming in? Will you carry out suggestions, including dietary modifications, that you may be recommended?)

Please list any surgeries or major health incidents (accidents, etc.) in your life and the date of occurrence:



If you experience any physical pain, please indicate where and since when:

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How would you characterize your physical pain?

- dull/achy   
  sharp/stabbing   
  burning   
  tingling /numbness   
  electrical  
 continuous   
  comes and goes   
  fixed location   
  moves around   
  shooting/ radiating

**Symptoms Survey**

Please indicate the symptoms or conditions you currently experience or have experienced them in the past:

| Earth                                       | Currently                | Past                     | Wood                        | Currently                | Past                     |
|---|--------------------------|--------------------------|-----------------------------|--------------------------|--------------------------|
| Excessive appetite                          | <input type="checkbox"/> | <input type="checkbox"/> | Eye Problems                | <input type="checkbox"/> | <input type="checkbox"/> |
| Loose stools / diarrhea                     | <input type="checkbox"/> | <input type="checkbox"/> | Jaundice                    | <input type="checkbox"/> | <input type="checkbox"/> |
| Digestive problems <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Difficulty ingesting        | <input type="checkbox"/> | <input type="checkbox"/> |
| Gas or bloating                             | <input type="checkbox"/> | <input type="checkbox"/> | Belching                    | <input type="checkbox"/> | <input type="checkbox"/> |
| Obsession                                   | <input type="checkbox"/> | <input type="checkbox"/> | Acid Reflux / heart burn    | <input type="checkbox"/> | <input type="checkbox"/> |
| Worry thoughts                              | <input type="checkbox"/> | <input type="checkbox"/> | Easily Frustrated/ angered  | <input type="checkbox"/> | <input type="checkbox"/> |
| Lack of appetite                            | <input type="checkbox"/> | <input type="checkbox"/> | Depression                  | <input type="checkbox"/> | <input type="checkbox"/> |
| Fatigue                                     | <input type="checkbox"/> | <input type="checkbox"/> | Difficulty making decisions | <input type="checkbox"/> | <input type="checkbox"/> |
| Low energy after a meal                     | <input type="checkbox"/> | <input type="checkbox"/> | Gallstones                  | <input type="checkbox"/> | <input type="checkbox"/> |
| Sweet cravings                              | <input type="checkbox"/> | <input type="checkbox"/> | ringing in the ears         | <input type="checkbox"/> | <input type="checkbox"/> |
| Hemorrhoids                                 | <input type="checkbox"/> | <input type="checkbox"/> | Brittle hair or nails       | <input type="checkbox"/> | <input type="checkbox"/> |
| Low blood pressure                          | <input type="checkbox"/> | <input type="checkbox"/> | High cholesterol            | <input type="checkbox"/> | <input type="checkbox"/> |



| Fire                | Currently                    | Past                          | Metal                                      | Currently                                 | Past                     |
|---------------------|------------------------------|-------------------------------|--|---|--------------------------|
| Insomnia            | <input type="checkbox"/>     | <input type="checkbox"/>      | Cough                                      | <input type="checkbox"/>                  | <input type="checkbox"/> |
| Heart palpitations  | <input type="checkbox"/>     | <input type="checkbox"/>      | Shortness of breath                        | <input type="checkbox"/>                  | <input type="checkbox"/> |
| Nightmares          | <input type="checkbox"/>     | <input type="checkbox"/>      | Decreased sense of smell                   | <input type="checkbox"/>                  | <input type="checkbox"/> |
| Mentally restless   | <input type="checkbox"/>     | <input type="checkbox"/>      | Colitis/diverticulitis                     | <input type="checkbox"/>                  | <input type="checkbox"/> |
| Chest pain          | <input type="checkbox"/>     | <input type="checkbox"/>      | Tightness in the chest                     | <input type="checkbox"/>                  | <input type="checkbox"/> |
| Poor memory         | <input type="checkbox"/>     | <input type="checkbox"/>      | Constipation                               | <input type="checkbox"/>                  | <input type="checkbox"/> |
| Sadness/loneliness  | <input type="checkbox"/>     | <input type="checkbox"/>      | Grief/ Nostalgia                           | <input type="checkbox"/>                  | <input type="checkbox"/> |
| Agitation/Fidgeting | <input type="checkbox"/>     | <input type="checkbox"/>      | Claustrophobia                             | <input type="checkbox"/>                  | <input type="checkbox"/> |
| <br>                |                              |                               |  |   |                          |
| Water               | Currently                    | Past                          | Blood & Dampness                           | Currently                                 | Past                     |
| Lower back pain     | <input type="checkbox"/>     | <input type="checkbox"/>      | Arthritis                                  | <input type="checkbox"/>                  | <input type="checkbox"/> |
| Knee pain/ problems | <input type="checkbox"/>     | <input type="checkbox"/>      | Sluggishness/Grogginess                    | <input type="checkbox"/>                  | <input type="checkbox"/> |
| Hearing impairment  | <input type="checkbox"/>     | <input type="checkbox"/>      | Nausea                                     | <input type="checkbox"/>                  | <input type="checkbox"/> |
| High or low libido  | <input type="checkbox"/>     | <input type="checkbox"/>      | Heavy feeling                              | <input type="checkbox"/>                  | <input type="checkbox"/> |
| Hair loss           | <input type="checkbox"/>     | <input type="checkbox"/>      | Dark circles under eyes                    | <input type="checkbox"/>                  | <input type="checkbox"/> |
| Urinary problems    | <input type="checkbox"/>     | <input type="checkbox"/>      | Blood clotting disorder                    | <input type="checkbox"/>                  | <input type="checkbox"/> |
| <br>                |                              |                               |  |   |                          |
| I usually feel :    | <input type="checkbox"/> Hot | <input type="checkbox"/> Cold | <input type="checkbox"/> I'm often thirsty | <input type="checkbox"/> Dry mouth/throat |                          |

**For Women**

Age of first period:                      Date of last period:                      Number of days between periods:



Number of pregnancies:

Miscarriages:

Abortions:

Are you currently sexually active?  Yes  No

Partners are:  Men  Women

Number of days of flow:

Please indicate color of blood and number of pads/tampons per day of flow below:

Color: \*Pale/light red \* Bright red \* Dark red/brown | Cramping: \* Mild \*Moderate \*Severe | # of pads: \*1-3 \*4-7 \*8+

Day 1,2

Day 3,4

Day 5+

Please indicate if you experience the any of these symptoms during your menses:

- Lower back pain  Diarrhea  Constipation  Moodiness/Weepy  Breast pain/soreness
- Blood clots  Increased appetite  Decreased appetite  Headache
- Nausea  Insomnia  More tired  Hemorrhoids
- Bloating  Down-bearing sensation  Scant or late menses  Irregular menses

Please indicate if you experience any of these other gynecological symptoms:

- Vaginal dryness  Profuse vaginal discharge  Yeast infections  Urinary tract infections

Please indicate if you have been diagnosed with any of the following:

- Fibroids  Fibrocystic breasts  Endometriosis  Ovarian Cysts  Polycystic Ovary Syndrome
- Pelvic Inflammatory Disorder

Please list any STDs you have: \_\_\_\_\_

### For Men

Date of your last prostate exam:

Are you currently sexually active?  Yes  No

Partners are:  Male  Female

Please list any STDs you have: \_\_\_\_\_



Please explain any concerns you may have with your sexual function or libido:

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### Lifestyle

How many hours of sleep do you get each night? \_\_\_\_\_

Do you experience:  Difficulty falling asleep  Staying asleep  Interrupted sleep

Nightmares  Vivid dreams  Wake up not well-rested/groggy

How many bowel movements do you have in a day or week? \_\_\_\_\_

Are your bowel movements:  Well-formed  Loose  Small pebbles  Tan  Almost black

Easy to pass  Difficult to pass  Sticky, like you have to wipe a lot

How would you rate your energy level on a scale of 1-10, with 10 being the highest: \_\_\_\_\_

How would you rate your stress level on a scale of 1-10, with 10 being the highest: \_\_\_\_\_

Please list your primary sources of stress: \_\_\_\_\_

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How much do you think about them? How much do they impact your life?

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How many hours do you work per week? \_\_\_\_\_ Do you like your work? \_\_\_\_\_

What do you do in order to manage your stress and take care of yourself?

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Did I miss anything? Anything else you'd like me to know?

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