New Earth Acupuncture & Nutritional Wellness, LLC

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Greendale Wellness Center
5651 Broad Street
Greendale, WI 53129
414.736.0830

Acupuncture/Nutrition/Whole Food Supplements

Welcome!

I am pleased to welcome you to New Earth Acupuncture & Nutritional Wellness, LLC and thank you for choosing me to partner with you in achieving your health goals. My mission is to offer the highest quality healthcare possible by treating the root cause of your health concerns so you can enjoy a balanced life with more energy, awareness, and peace of mind.

In the following pages, you will find new patient information along with questions designed to provide vital information necessary to individualize a program specific to your health goals. This individualization of the treatments is one of the strong points of Oriental Medicine. It is why people may experience broad changes within themselves after receiving acupuncture for a specific complaint. The health history is rather detailed and usually takes 15-20 minutes to complete. Please complete the entire questionnaire prior to your first appointment and bring it with you. Some of the questions may seem unrelated to your complaint, but they may play a major role in diagnosis and treatment. You may also arrive early to your first appointment and complete the questionnaire in our waiting area.

What to Expect On Your First Visit

- Allow yourself 1.5-2 hours for your first treatment and 1 hour for follow-up visits.
- Always eat before you come for the treatment. You should not have acupuncture when you are hungry.
- The practitioner will begin your evaluation by asking you many questions. In addition, the practitioner may take your pulse, look at your tongue, palpate specific points, or check your range of motion.
- Generally speaking, the practitioner will not discuss your diagnosis in oriental medical terms. It is usually confusing and often misleading for patients to hear the terminology we use within oriental medicine to describe their condition. For example, a diagnosis of Kidney Qi and Yin Deficiency would not mean very much to you as a patient and could make you think there is something wrong with your physical kidneys when it is likely that there is not.

•Upon conclusion of your first visit, the practitioner will make a treatment recommendation. This may include a certain number of treatments within a certain amount of time. Your practitioner may recommend herbal medicine, supplements, nutritional and lifestyle changes, or refer you to another healthcare provider.
Please take these suggestions seriously as they are based on years of experience as well as your individual circumstances, and are important to your health and well-being.
•Please utilize this time to ask any questions that you may have.

Attire for Acupuncture Patients
Please wear loose, comfortable clothing. Gowns and sheets are available if you are wearing clothing that prevents access to areas of the body that need to be treated. Draping will be provided to ensure modesty. In consideration of others, please refrain from wearing perfume/cologne, strongly scented oils or lotions. For your safety and comfort, **please turn off cell phones and pagers prior to your treatment.**

Cancellation Policy
A minimum of 24 hours notice is required when canceling or changing an appointment. If you have missed or rescheduled an appointment with less than 24 hours notice, you will be responsible for the full charge of the office visit. We ask that you make every effort to arrive on time to your scheduled appointment time. If you are running late, please telephone 414.736.0830 as we may have to reschedule your appointment if we cannot accommodate you.

Payment & Insurance
Payment is required at the time of service. **We accept cash or check**. Returned checks will incur a fee of $25.00.

We do accept Veterans Benefits.
At present, we do not accept any insurance plans. We can provide you with a form to submit to your insurance company for reimbursement. Please check with your insurance company for their rules about acupuncture coverage and reimbursement.

Acupuncture is tax deductible and reimbursable under most health care spending count plans.

New Earth Acupuncture and Nutritional Wellness does not provide primary care medicine. Acupuncture is a wonderful complement to Western Medicine but it is not a substitute for it. If you think you have a serious health condition or want a medical diagnosis you need to see a primary care physician. We can provide complementary care for conditions that require a physician's attention. For example, side effects of chemotherapy are effectively treated with acupuncture. However, you need to take responsibility for your own health.

What To Expect AFTER Your First Visit

•After the treatment, the most common feeling is being relaxed but some people feel energized. Take a few minutes to rest and drink some water.

•Note how you feel, physically, mentally, and emotionally until the next treatment and inform the practitioner of any changes at your next visit so your treatment can be modified if necessary.

•On rare occasions one's original symptoms may briefly get worse after the first treatment. A flare-up typically occurs later on the day of your treatment for a few hours and then improvement and relief follow. In the long run, acupuncture does not make symptoms worse.

•After the treatment, please do not exercise vigorously for the rest of the day. A mild walk is fine.

•Please avoid exposure to extreme hot or cold temperature after the treatment.

•If you have any additional questions or concerns after your treatment, please do not hesitate to contact me @ **414.736.0830**

New Earth Acupuncture & Nutritional Wellness, LLC

This is a CONFIDENTIAL questionnaire to help us determine the best treatment plan for you. Please fill it out as completely as possible even if you do not feel certain questions pertain to your present condition. If you need more room, please use the other side of these sheets. Thank you.

Personal Information

Last Name_____ First Name _____Middle Initial___

Gender M F Date of Birth: _____Age:_____ Height:_____ Weight:_____

Street
Address:_____

City: _____ State:_____ Zip:_____

Phone -Daytime (_____)_____**Home/ Work /Mobile** *circle one*

Alternate Phone # (_____)_____**Home/ Work/ Mobile** *circle one*

Email address: _____

Place of
Employment:_____Occupation:_____

Relationship Status: ☐ single ☐married ☐ living w/partner ☐ divorced

☐ separated ☐ widowed ☐ other_____

Emergency Contact:
Name:_____Relationship:_____

Contact Phone # (_____)_____ **Home/ Work/ Mobile** *circle one*

If under age 18, person responsible for your account_____

Whom should we thank for referring you to our office?
_____

Have you had acupuncture therapy before? Y/N

If yes, when and with whom?_____

Did you have a positive experience/ outcome?_____

Primary Care Doctor_____ Specialty_____

Other Doctors You See _____ Specialty_____
Other Doctors You See _____ Specialty_____

MAIN COMPLAINT
What is the main health complaint/concern for which you are seeking treatment?
How did this condition develop/how long have you had this condition?
What makes it better or worse?
Please mark on the scale form 1-10 the severity of the condition (1 = no symptoms, 10 = worst ever) **1 I----------I----------I 10**

<u>Additional Complaint(s)</u> **in order of importance to you today**

Health History

Check whether you or someone in your family have/had the condition. Note the year for the conditions you have had.

	YOU	your FAMILY
Cancer	☐	☐
-type(s)_____		
Diabetes	☐	☐
Hepatitis (A, B, C)	☐	☐
High Blood Pressure	☐	☐
Heart Disease	☐	☐
Stroke	☐	☐
Seizure disorder	☐	☐
Thyroid Disease	☐	☐
Asthma	☐	☐
osteoporosis	☐	☐

	YOU	your FAMILY
Herpes	☐	☐
AIDS/HIV	☐	☐
Other STD	☐	☐
- type(s)_____		
Rheumatic Fever	☐	☐
Alcoholism	☐	☐
Allergies	☐	☐
- type(s)_____		
Mental illness	☐	☐
- type(s)_____		
Kidney disease	☐	☐
Anemia	☐	☐

Notes:

Notes:

Exercise

Do you exercise regularly? ☐Y ☐ N
If yes, what and how often?
_____
_____
_____
_____
_____

Do you enjoy the exercise you perform ☐Y ☐ N

Habits

	Amount/Week	If quit, year?
Coffee/Tea	_____	_____
Soda	_____	_____
Tobacco	_____	_____
Alcohol	_____	_____
Drugs	_____	_____

Do you have or are you any of the following? ☐ Pacemaker ☐ Electronic Implants

☐ Metal Implants ☐ Severe Bleeding Disorders ☐ Pregnant ☐ HIV Positive ☐Hepatitis A/B/C

MEDICALCONDITIONS Please list conditions & surgeries you have or have had and year diagnosed.	**ALLERGIES** Medications, Seasonal, Environmental, Food	**OCCUPATIONAL CONCERNS** Check (√) if your work exposes you to the following.

Year	Condition/Surgery/Injury		Occupation:
			☐ Stress
			☐ Heavy Typing/Computer Use
			☐ Hazardous Substances
			☐ Heavy Lifting
			☐ Other

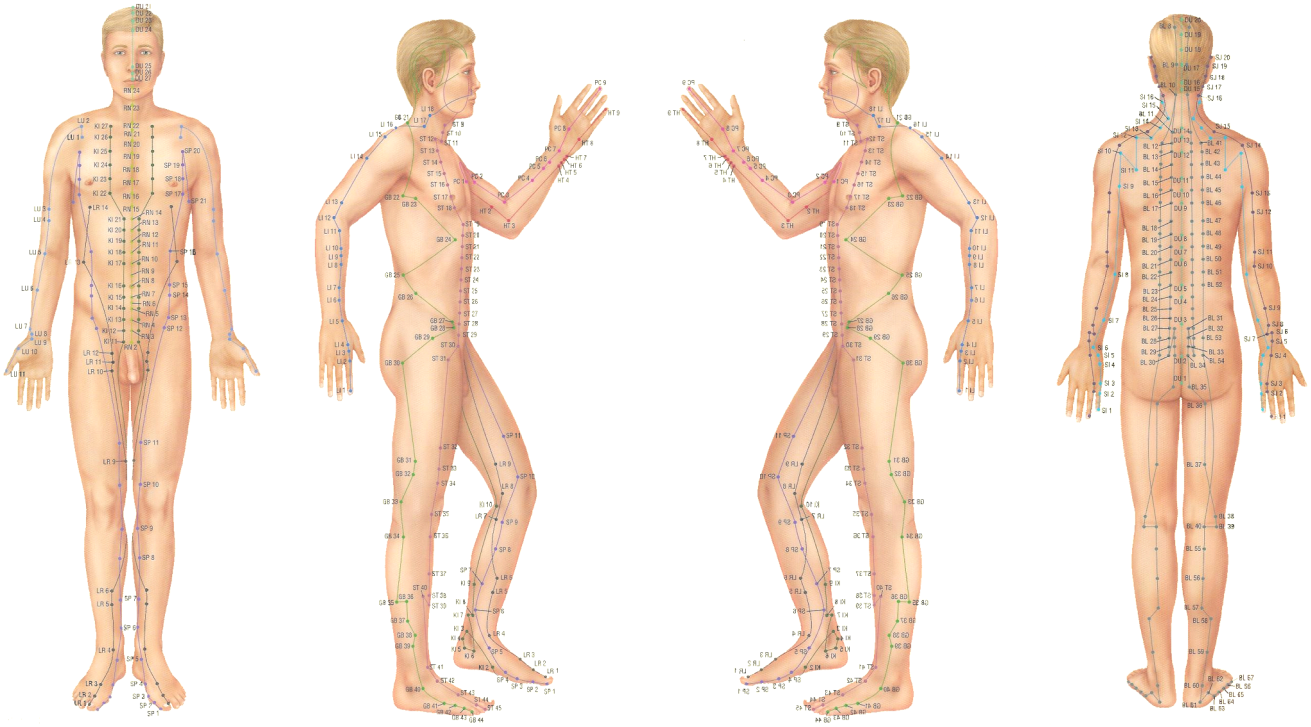
Medications: Please list all prescription medications you use. Include those which you may only use occasionally. Include inhalers, eye drops, nose sprays and topical creams.

Prescription Name	Purpose	How Long	Dose	How Often	Last Dose

Supplements: Please list all vitamins and supplements you use.

Name	Purpose	How Long	Dose	How Often	Last Dose

PAIN PATIENTS, please indicate on the figures below the areas of the body you experience your pain:



Is the Pain: ☐ sharp ☐ burning ☐ dull ☐ aching ☐ cramping ☐dull ☐ moving ☐ fixed

MENSES

Are you pregnant? ☐ Yes ☐ No
Age at first menses:_____
Length of full cycle:_____ days
Length of menses: _____days
Last menses start date: ___/___
# of pregnancies:_____
# of births:___ premature ___
#Caesareans _____
# of miscarriages:_____
# of abortions:_____
____Changes in body/psyche prior to menstruation (PMS)

___Heavy periods
___Light periods
___Painful periods
___Irregular periods
___Mid-cycle spotting
___Mood changes
___Fatigue w/menses
___Clots
____Breast tenderness/pain
____ Low backache

___Digestive changes w/menses
___Cysts/Fibroids
___Endometriosis
___ Vaginal discharge
___Genital sores
___Yeast infections
Form of Birth control:_____
Date of Last PAP test_____

MENOPAUSE

Age at last menses:____
Year menopause began:_____
___Vaginal dryness
___hot flashes _____x/day
Night sweats _____x /week
___Loss of sex drive

URINARY

Fluid in = fluid out? Y/N
___Incontinence
____Kidney stones
____Urgency to urinate
____Frequent urination
____Painful urination
____Burring urination
____Cloudy urine
____Blood in urine

Symptom Survey

Please mark an X on the scales and "check" the symptoms or conditions you experience <u>frequently</u>:

TEMPERATURE

How warm/cold do you feel in degrees relative to other people, do you wear more layers, etc.

COLD I----------I----------I WARM

__Cold hands/feet
__Chills
__Cold "in the bones"
__Areas of numbness
Thirst for cold/hot drinks (circle)
___Absence of thirst
__Excessive thirst
__Night sweats
__Unusual sweats
-when am/pm
-where on body_____
__Thirst, but no desire to drink
__Hot hands, feet, chest
__Hot flashes
__Hot in afternoon
___Hot at night

MOISTURE

Your overall body moisture (hair, skin, mouth, bowels, etc.)

DRY I----------I----------I OILY

___Dry skin
___Dry eyes
___Dry, brittle nails
___Dry mouth
___Dry lips
___Dry throat
___Dry nose/nosebleeds
___Edema/swelling
___Rashes
___Itching
___Dandruff
___Oily skin
___Oily hair
___Pimples
___ Weight gain/loss

DIGESTION

DIARRHEA I----------I----------I CONSTIPATION

BM: How often? ___ x/every ___days
Stools keep shape? Y/N (circle)
___Alternating diarrhea & constipation
___Indigestion
___Gas
___Bloating
___Belching
___Poor appetite
___Nausea/vomiting
___Bad breath
___Heartburn
___Excessive hunger
___Dry stools
___Stools difficult to pass
___Tired after BM
___Foul smelling stools

ENERGY

LOW I----------I----------I HIGH

__Sudden energy drop
-time of day:___ am/pm
__Energy drop after eating
__Fatigue
__Dependence on caffeine/stimulants
__Wired/ungrounded feeling
__Body/limbs feel heavy
__Body, limbs feel weak
__Shortness of breath
__Heart palpitations
__Blood pressure: High/Low
__Bleed/Bruise easily
__Hard to concentrate
__Poor memory
__Dizziness/Lightheaded
__Headaches:____ x/week

EYES, EARS, NOSE THROAT

__Poor vision
__Night blindness
__Red eyes
__Itchy eyes
__Spots in front of eyes
__sinus congestion
___Phlegm (color_____)
___Poor hearing
___Ringing in ears
___ Frequent colds
___Sore throat
___Dental problems
___Mouth sores
___Cough

SLEEP

hours p/night____
___ Difficulty falling asleep
____Wake x/night @ _____am/pm
____Wake to urinate ____times
____Disturbing/vivid dreams
____Restless sleep
____Not rested upon waking

EMOTIONS

What emotions dominate your experience?

___Anger
___Irritability
___Anxiety
___Worry
___Over thinking
___Sadness / Grief
___Indecision
___Depression
___Joy
___Fear
___Timid/Shy
____Other:_____

What do you do to relax?_____

TRAVEL:

Have you ever traveled or lived outside the U.S.? o Yes o No
Any health problems when abroad? o Yes o No
What?_____