



The Foxwell centre
of holistic therapies

Acupuncture Questionnaire

Full Name:	Date:
Address:	GP Name / Address:
D.O.B / Age:	Telephone Number:
Emergency Contact Details Name: Relationship: Telephone Number:	Occupation:

Please state why you have chosen Acupuncture and what you would like to achieve with treatment:

Personal information

Please list any existing medical conditions, including chronic illnesses, pacemakers, major surgery etc:

Please list any prescribed medication:

Do you have any allergies?

Yes/No

Please list:

Any problems lying flat?

Yes/No

What time did you last eat/drink?

Eat:

Drink:



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Please circle the following on a scale of 1 – 10 (with 1 being the least and 10 being the most):

1. Energy and Drive

How well do you feel? 1 2 3 4 5 6 7 8 9 10
How much energy do you have? 1 2 3 4 5 6 7 8 9 10

2. Emotional Conditions

Happy 1 2 3 4 5 6 7 8 9 10
Stressed 1 2 3 4 5 6 7 8 9 10
Worried 1 2 3 4 5 6 7 8 9 10
Angry 1 2 3 4 5 6 7 8 9 10
Depressed 1 2 3 4 5 6 7 8 9 10
Sad 1 2 3 4 5 6 7 8 9 10
Anxious 1 2 3 4 5 6 7 8 9 10
Fearful 1 2 3 4 5 6 7 8 9 10
Grief 1 2 3 4 5 6 7 8 9 10
Joy 1 2 3 4 5 6 7 8 9 10

3. Sleep

How well do you sleep? 1 2 3 4 5 6 7 8 9 10
Do you suffer with insomnia? Yes/No

4. Appetite and Digestion

Do you have a preference for hot or cold food? Hot/Cold/Neither
Do you suffer with distension after eating? Yes/No
Do you always feel hungry? Yes/No
Do you have no appetite? Yes/No

5. Taste

Please state the taste you feel you have in your mouth when not eating:

Bitter	Salty	Sweet	Sour
Pungent	Metallic	No Taste	Halitosis

6. Vomiting

Do you suffer with vomiting? Yes/No



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7. Thirst

Do you have a preference for hot or cold drinks?	Hot/Cold/Neither
Do you have an excessive thirst?	Yes/No
Do you have no thirst?	Yes/No

8. Bowel Function

Do you suffer with constipation?	Yes/No
Do you suffer with diarrhoea?	Yes/No
Do you have blood in your stools?	Yes/No
Colour of stool:	Light brown/Dark/Pale/Green
Do you suffer with intestinal noises?	Yes/No
Do you have flatulence?	Yes/No

9. Kidney and Bladder Function

Do you have any problems when passing urine?	Yes/No
Do you suffer with retention of urine?	Yes/No
Any odour noted on passing urine?	Yes/No

10. Sweating

Do you sweat excessively?	Yes/No
Do you not sweat even if unwell?	Yes/No
Do you suffer with night sweats?	Yes/No

11. Pain in the Body

Do you suffer with headaches?	Yes/No
Do you suffer with dizziness?	Yes/No
Any pains in the chest?	Yes/No
Any pains in the side or ribcage?	Yes/No
Any pains in the epigastrium/abdomen above navel?	Yes/No
Any pains in the lower abdomen/groin or pelvis?	Yes/No
Any back pains?	Yes/No
Any pains in the arms?	Yes/No
Any pains in the legs?	Yes/No
Any numbness in the body?	Yes/No

12. Eyes

Any problems with the eyes?	Yes/No
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13. Ears

Do you suffer with tinnitus? Yes/No
Do you suffer with deafness? Yes/No

14. Nose

Any problems with the nose? Yes/No

15. Reactions to Temperature

Do you feel hot or cold? Hot/Cold/Neither
Do you dislike the heat or cold? Heat/Cold/Neither

16. Female Conditions

Any problems with your menstrual cycle? Yes/No
Any pain before, during or after your menstrual cycle? Yes/No
Any discharges? Yes/No
Have you ever been pregnant? Yes/No
Do you have any menopausal symptoms? Yes/No
Any infertility problems? Yes/No
Do you suffer with a low libido? Yes/No

17. Male Conditions

Any seminal emission during the night? Yes/No
Do you suffer with a low sperm count? Yes/No
Any infertility problems? Yes/No
Do you suffer with a low libido? Yes/No
Any pain in the groin/testes? Yes/No