Iffley Acupuncture Clinic

Patient Evaluation

PLEASE READ BEFORE YOU BEGIN COMPLETING THE QUESTIONNAIRE

This questionnaire is provided to aid you during your initial consultation. It will also help you to begin thinking about your body in ways that may not have previously been accessible. Its length should not in any way deter you before you seek or embark upon treatment. Please be sure that it is optional and need only be completed should you wish to do so. It will provide you with some insight into the sort of questions that you will be asked during your first visit and at the same time, help you think more carefully about your condition, general health and wellbeing. Although quite extensive, this does not mean that you need to provide extended answers, you need only do so where and when you think it appropriate. The questions that are raised in each section in italics serve only as prompts and whilst it is hoped that you will complete all sections, you should not attempt to answer each of these questions. Try to use them as prompts or a route for evaluating your own circumstances.

During your first consultation you may find that questioning may not necessarily be so detailed, with greater attention being focussed more on your specific circumstances; less time therefore being allocated to the least relevant. If you are seeking treatment for a recently experienced trauma then questioning is less likely to be as detailed or expansive as it would be if you are experiencing a recurrent or long term problem.

Iffley Acupuncture Clinic

Patient Questionnaire

Date:

Name: Address:

Age:

Date of Birth:

Occupation:

Marital Status: Telephone:

Children: Mobile:

Height: Work:

Weight: General Practitioner:

Smoker:

Alcohol:_____units/glasses/day/week

Medications:
Use this space to list all the medications that you are taking, including frequency and dosage.

Remedies/Minerals/Vitamins etc:
Use this space to list any nutritional supplements, herbal remedies or similar.

Other:
Use this space to list any other treatments you are undertaking, both conventional and alternative /complementary.

Primary Problem/circumstances:

In this section, please give the reasons why you have decided to pursue acupuncture and where appropriate, your primary concern/problem. Try to think about the duration of your condition, it's exacerbations and ameliorations (i.e. when and what makes it worse or better). If you are experiencing pain, then use the attached charts to help you pin point the actual location and its nature.

Secondary Problems /Symptoms:

You can record in this section any other patterns/conditions/symptoms that you hope to address whilst attending the clinic

Temperature.

In this section we are interested in your subjective or objective sense of temperature. Do you feel hot or cold? Are there parts of you that are hot or cold? Do some parts of you feel hot or normal, whilst other parts are cold, or visa versa? Do you feel hot or cold all over? When do you feel hot/cold? In the morning / in the afternoon / in the evening or at night time? Perhaps all the time?

Thirst:

Are you often thirsty or are you rarely thirsty. Do you suffer from a dry mouth and throat? Are you more thirsty in the morning / afternoon / evening / or at night? Do you feel thirsty but find that you don't drink or drink only small quantities? Do you drink copious amounts? Do you prefer a hot drink to a cold one or visa versa?

Sweating:

Do you experience sweating that seems inappropriate? Do you experience spontaneous sweating? Do you sweat in the morning / afternoon / evening or at night? Do you sweat out of proportion to the activity you are undertaking? Do you encounter a particular or unpleasant odour with your sweating? Do you rarely encounter sweating?

Head: *(please also see pain charts)*

Do you experience headaches / heaviness in the head / muzziness / forgetfulness / dizziness / light-headedness etc? Try to record as accurately as you can the frequency and timing of your symptoms as well as their location. Use the attached charts to help you.

Eyes:

Please record any problems that you experience with your eyes, both within and behind. This might include itching, dryness, redness and soreness. It may also include pain that may or may not be linked with headaches. You may also encounter dryness or alternatively excessive watering or tearing. We will also be interested in the experience of visual changes if any, including spots in your visual field, floaters, loss peripheral vision, flashing lights etc.

Ears:

In this section we are concerned not only with hearing and or loss of it, but also the presence of tinnitus (ringing or fluttering); it may help to note whether you experience a high or low pitched tinnitus and at what time you encounter it. Please also record whether you have encountered any repeated infection and the repercussions of this infection if any. Record also whether there has been any discharge or eczema in or around the ear.

Mouth:

Do you encounter any particular taste or sensation in your mouth? You may encounter a bitter, metallic or sweet taste in your mouth that is not associated with eating. Some patients also report a sticky taste in their mouths that may or may not be associated with a feeling of nausea. Do you suffer from bad breath or halitosis?

Eating Patterns:

Do you eat regularly and at regular intervals? Do you eat breakfast lunch and supper /dinner? Do you manage to eat in a relaxed environment or do you eat on the go, eating when time becomes available? What do you eat? What foods agree or disagree with you? Do you eat foods that are cooked and hot or conversely do you consume a lot of raw food and salad? Do you like and eat a lot of hot / spicy / oily or greasy food or do you have a 'sweet tooth'?

Appetite:

Do you have a seemingly healthy appetite? Or are you experiencing a loss or indeed an excessive appetite? Is your appetite better or worse at a given time of day?

Digestive discomfort:

Do you encounter pain before, during or after eating? Do you encounter a feeling of fullness, bloating or distension in your tummy? If so where exactly do you feel it? Do you encounter nausea, vomiting, reflux or heartburn? Do you experience a feeling of heat or conversely a feeling of cold in your tummy / abdomen? If you encounter pain or discomfort, is this eased by eating or worsened?

Bowel:

Do you have regular or irregular bowel movements? How often do you go? Do you experience loose stools, diarrhoea or conversely, difficulty and constipation? Do you experience variations in your stools; sometimes loose and sometimes more constipated? Are your bowel movements affected by your emotions? Do you encounter pain, soreness or burning during defecation? Are these sensations eased or worsened by defection? Do you experience any bleeding from you anus? Do you notice any mucous in your stool?

Urination:

Do you urinate frequently or infrequently? Do you have to urinate at night? Is there any hesitancy or conversely is there any loss of control or dribbling? Do you encounter any urinary difficulty or pain/ burning? What colour is your urine? Is it cloudy? Does it have a particular odour? Do you encounter any urinary tract infections?

Body: .

Do you encounter any pain and or stiffness that you are not seeking treatment for? If so where is it? How often and when does it occur? Do you encounter any numbness or tingling and if so, when and how often?

Skin, nails and hair:

***Skin**: Is your skin dry / itchy / blotchy / red / sore / scaly / oily or greasy. Do your experience rashes / acne or spots? Try to describe the nature of any problems that you encounter and where and when they are experienced.*

***Nails**: Do your nails break easily? Are they ridged or discoloured in any way? Do you experience any fungal type infections in you toe nails?*

***Hair**: Is you hair in good condition? It dry / brittle / split/ greasy. Are you loosing or have you lost hair prematurely or inappropriately? Are you greying prematurely?*

Emotions:

What emotions are prominent in your life? Are you fundamentally happy and content and do you experience emotions appropriately and in normal response to your circumstances? Do you experience either anger / frustration / irritation / impatience / worry or over-thinking / anxiety / panic / fear or sadness in excessive amounts or more than desired? Do you think that you experience depression? Are your emotions labile, swinging one way, then another? Are you able to let your emotions come and go or do they preoccupy you? Do you get stuck? Are they affected by your menstrual cycle? Are you happy at work? Are you happy at home? Are you experiencing problems with your relationship/s? Have you lost anyone dear to you and or, are you experiencing grief? Have you encountered any significant emotional traumas?

Heart/palpitations:

Do you ever experience any chest pain? Do you experience a feeling of pressure on your chest? Do you experience a feeling of uneasiness in the chest? Are you aware of your heartbeat? Are you aware of changes to your heartbeat or any irregularities? If you experience any of these, when do they occur and with what intensity? Have you had your blood pressure taken recently? What was your last blood pressure reading? Do you have high blood pressure?

Sleep:

Do you sleep soundly or restlessly? Are you aware of your dreams? Do you experience nightmares? Do you have trouble getting off to sleep / waking in the night / waking early in the morning? Do you experience one or more than one of these problems? Are you troubled by any physical or emotional symptoms at night? Do you notice any patterns to your sleep or lack of it?

Energy Levels

Do you have an abundance of energy? Do your energy levels fluctuate? Are you tired: some of the time / much of the time /all of the time? Are you tired: on waking and in the morning / in the afternoon / or at night? Are you tired: after eating / before eating/ Are your energy levels affected by your emotions? Are your energy levels affected by you menstrual cycle?

Breathing/Respiration:

Do you have any breathing difficulty? Do you encounter breathless: spontaneously / on normal physical activity? Do you notice a significant amount of phlegm or mucous in or from your nose / in your throat/ in your chest or lungs? What colour is the phlegm or mucous? Is it easy to expectorate (bring up or get out) or is it quite difficult? Is it copious or is it scanty? Do you have asthma? Do you use inhalers prescribed by your doctor?

Medical History:

Please record any significant medical history including treatment. This might include childhood illnesses, infectious illnesses, prolonged illness, hospitalisation, surgery, medications and medical investigations for a given illness etc.

Family History:

If possible please record any family medical history or patterns; that of your bothers and sisters as well as you mother and father. Where family members have died, please record the reasons for death.

Questions for Men and Women:

You may not feel that this area of questioning is important or relevant to you, but in fact the information that you provide can offer important insights into you overall body functioning as well as specific difficulties. Remember, you need only answer questions that you feel comfortable with. We will not always seek answers to these questions during consultation and only do so if it is relevant to your circumstances. However if you have a particular problem that you are seeking help with or need reassurance with, then please be sure to raise the issue at consultation.

Libido and sexual problems:

Men: Libido and sexual problems:

Are you encountering any sexual problems or difficulties? Do you feel that you have a normal and healthy sex drive or are you encountering a loss of libido? Are these difficulties if present, recent / long term / cyclical? Do you have problems obtaining or maintaining an erection? Do you suffer from premature ejaculation? Do you experience frequent 'nocturnal emissions / spontaneous ejaculation at night? Do you encounter tiredness or dizziness after ejaculation? *? Do you experience pain during intercourse? Do you feel that these problems if present are physical or have an emotional origin? Do you or have you encountered any infections such as / Candida or do you encounter any vaginal itching or soreness? Have you received treatment for any Sexually Transmitted Diseases /STD's?*

Women: Libido and sexual problems:

Are you encountering any sexual problems or difficulties? Do you feel that you have a normal and healthy sex drive or are you encountering a loss of libido? Are these difficulties if present, recent / long term / cyclical? Do you have difficulty reaching orgasm? Do you experience problems with arousal? Do you experience vaginal dryness? Do you ever encounter headaches after orgasm? Do you experience pain during intercourse? Do you feel that these problems if present are physical or have an emotional origin? Do you or have you encountered any infections such as / Candida or do you encounter any vaginal itching or soreness? Have you received treatment for any Sexually Transmitted Diseases /STD's?

Pain:

A clear description of pain will enable a more accurate diagnosis and a more appropriate treatment principle. You can use the list below to help you build a more succinct description of you condition and pain. There are five areas that you might consider and a number of charts/ diagrams that will enable you to be clearer about it's location.

1. Nature of Pain

There many different types of pain and nature of them can indicate the cause of your condition. Please use the table below to help you identify the nature of your pain, not its location.

Type of pain	Description	Tick
Soreness	*This is not a severe pain, it is more dull in nature and frequently occurs in the arms and legs*	
Heavy	*A relatively dull ache or pain that is accompanied by a feeling of 'heaviness'. It can be felt in either the limbs, head or whole body*	
Distending	*Pain that is accompanied by a feeling of distension or bloating, often felt in the chest, beneath it the chest, the flanks and in the abdomen. It is frequently experienced in digestive complaints and in premenstrual conditions. It may actually be seen.*	
Fullness	*An ache that is accompanied by 'fullness'. Fullness is different from distension in that a person actually feels full and its location is possibly hard to touch, a little like one feels after eating a big meal. It is usually felt in the area just below the sternum and above the navel, (the epigastrium) or in the abdomen or belly*	
Colicky	*Colicky pain is spastic or cramping in nature. It also usually felt in the epigastrium or abdomen. It may be associated with painful periods*	
Spastic	*This is a sharp pain that is accompanied by a feeling of spasm. It may be felt in the arms and legs and possibly, the head.*	
Distressing	*Whilst all pain can be considered to be distressing, this type of pain will be accompanied by feelings of restlessness, unease, anxiousness and perhaps palpitations. The pain may be felt in the chest, epigastrium and or the abdomen.*	
Stuffiness	*Pain accompanied by a feeling of 'stuffiness' is a little like 'fullness' but less severe or intense. It is more frequently encountered in the chest or epigastrium.*	
Pushing	*Pushing pain is experienced with a feeling like something is 'pushing' outwards. It can occur in the epigastrium and the hypochondrium, (an area just beneath the ribs and more to the sides than the centre).*	
Pulling	*This is a sharp pain that feels like the skin is being pulled. It occurs only on the head.*	
Cutting	*'Cutting' pain is very sharp in nature and feels like a knife. It is frequently experienced in the abdomen and may accompany menstrual pain*	
Throbbing	*This type of pain is often severe and is accompanied by a feeling of 'throbbing' or pulsing. It is often felt in the head.*	
Boring	*'Boring' pain is comparable to 'cutting' pain, it is severe in nature and may feel like the point of a knife or nail. It is usually found in one location only. It may be felt in the head, chest, epigastrium, hypochondrium or the abdomen*	
Other	*You may have another pain description that you use.*	

1.*Time of Pain*
Please use the list below to record the timing of your pain- tick the appropriate box

- ❑ Daytime pain
- ❑ Pain at night
- ❑ Intermittent pain
- ❑ Continuous pain
- ❑ Pain after eating
- ❑ Pain before eating
- ❑ Pain after defecation
- ❑ Pain before defecation and alleviated after it
- ❑ Pain before a period
- ❑ Pain during your period
- ❑ Pain after your period
- ❑ Mid-cycle pain

2. *Area of Pain*
Please tick the appropriate box

- ❑ Localized pain - is the pain fixed and occurring in one area

- ❑ Moving pain - does the pain occur in different locations or seem to wander from location to location

Please also feel free to draw on the accompanying charts to help you locate the areas of pain more accurately.

3. Response of Pain to Pressure and Environment or Temperature
Please tick the appropriate box.

Is the pain:-

- ❑ Aggravated by pressure: does it hurt to touch?
- ❑ Alleviated by pressure: does it feel better for touch and or pressure?
- ❑ Aggravated by warmth or heat: does your condition get worse in warm or hot environments or times of the year?
- ❑ Alleviated by warmth: does it feel better in the warm weather / for a hot bath or shower / a warming meal or drink / a hot water bottle or something similar?
- ❑ Aggravated by cold: does it get worse in cool and cold weather / the application of an ice pack or something similar?
- ❑ Alleviated by cold: does it get better in cool and cold weather / the application of something cold?
- ❑ Aggravated by damp: does your condition get worse in damp weather?