Watford Acupuncture Clinic Online Questionnaire

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| Title: Mr./ Mrs./ Miss/ Ms. |  |
| Surname:  | Forename: |
| Date of Birth:  | Occupation: |
| Marriage Status :  | Mobile / Tel: |
| Home address: | Email address: |

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| Request for treatment & Consent for use of personal data*\* I request for acupuncture, moxibustion, infrared-lamp warming, acupressure massage, cupping, Chinese herbal medicine, and related treatment at Watford Acupuncture Clinic.**\* I consent to Watford Acupuncture Clinic contacting me by post, phone and email and keep me informed about news, events, activities and special offers.*Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| ***Chief Complain:***What is you main symptoms or discomfort ?***History of chief complain:***When did the symptoms start? Can you remember the exact date?How did the symptoms develop?What medical examination and diagnosis did you have?What treatment did you have and how did it work?Other details |
| ***Secondary and other Complains***Do you have other symptoms or discomfort? Please give details. |
| ***Present condition:***How is the main symptom at the moment?Please give details of the present issues.How is your energy? (Please rate it out of 10 if 10 is perfect)How is your appetite? (Please rate it out of 10 if 10 is perfect)Do you have healthy diet – balanced diet?Do you have lots of carbohydrate or sugar in your diet?How many cups of water do you drink per day? Do you feel thirsty?How often do you open your bowel? Is it normal shape like a banana?Do you have constipation or diarrhea? Is it hard or difficult?How is your sleep? (Please rate it out of 10 if 10 is perfect)What time do you go to bed?How long does it take you to fall asleep? Do you wake up often at night? How often?Are you refreshed in the morning?Do you feel stressed, anxious , depressed, or irritable? How long ?(If so, please rate it out of 10 if 10 is very bad)Do you smoke? If so , how many cigarettes a day?How many years have you been smoking?Do you drink alcohol?If so, how many unit per week?Do you use recreation drugs?Do you drink coffee?If so , how many cups a day?Do you exercise?What do you do? How often?Are you allergic to any food or medications? |
| ***Medical history***Please list the major medical conditions or accidents in your past, including medical examinations and treatments.Are you under any medications at the moment? |
| ***Menstruation***Do you have regular menstruation? How many days is your cycle?How many days does it last?Do you have pain? Please rate your pain out of 10.Do you have heavy, normal, or light amount of menstruation?How old were you when you started your menstruation/ |
| ***Family status***Are you married?Do you have children? How may? |

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Please also check if you have any of the following symptoms.

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| Symptoms  | Do you have it? |
| ***1)Taiyang symptoms*** |  |
| Feeling cold and chilly |   |
| Fever |   |
| Discomfort or cold feeling in the back of neck |   |
| Sweaty or clammy |   |
| Backache |  |
| Achy hands and feet |  |
| Calf spasm |  |
| Pain in the back of head |  |
| Feeling dizzy or light-headed |  |
| Blocked nose |  |
| Sneezing or cough |  |
| Runny nose |  |
| Leaky bladder |  |
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| ***ShaoYang symptoms*** |  |
| Feeling cold and hot alternatively |  |
| Headache in the temple area |  |
| Nausea or vomiting  |  |
| Tinnitus or reduced hearing |  |
| Discomfort in ears |  |
| Dizziness |  |
| Discomfort in the ribcage area |  |
| Achy shoulder |  |
| Feeling thirsty at night  |  |
| Bitter taste in mouth at night or in the morning |  |
| Feeling low, depressed or anxious |  |
| Tight or painful rib cabe |  |
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| ***Yangming Symptoms*** |  |
| Feeling hot or hot flush |  |
| High Temperature  |  |
| Feeling thirsty and drinking lots of water |  |
| Dry throat |  |
| Eye discomfort |  |
| Constipation |  |
| Feeling bloated and windy |  |
| Smelly wind |  |
| Stomach pain |  |
| No sweating |  |
| Frequent urination |  |
| Preference to cold water |  |
| Headache in forehead |  |
| Irritable sinus |  |
| Gum pain |  |
| Increased appetite |  |
| Sticky stool |  |
| Hard stool |  |
| Bitter taste in mouth during daytime |  |
| Oily face |  |
| Green nasal discharge |  |
| Green or yellow phlegm |  |
| Grinding teeth at night |  |
| Heavy chest or chest pain |  |
| Heart burn or burning in esophagus |  |
| Anxiety at night |  |
| Stomachache around belly button |  |
| Sweating only on the head or neck |  |
| Sweating in palms or feet |  |
| Itchiness all over the body |  |
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| ***Taiyin symptoms*** |  |
| Poor appetite |  |
| Feeling cold and chilly |  |
| Loose stool |  |
| Diarrhea  |  |
| Bloating in stomach |  |
| Palpitation |  |
| Feeling hungry frequently |  |
| Preference to warm food or drink |  |
| Weakness in arms and legs |  |
| Bloating in stomach after food |  |
| Gum bleeding |  |
| Shaking when you are hungry |  |
| Foamy urination |  |
| Mouth ulcer |  |
| Feeling drowsy |  |
| Swelling arms |  |
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| ***Shaoyin symptoms*** |  |
| Feeling sleepy during the day |  |
| Sore thoat |  |
| Night sweat |  |
| Losing memory |  |
| Swelling legs |  |
| Insomnia through the night |  |
| Feeling cold in low back and legs |  |
| Cold hands and feet |  |
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| ***Jueyin Symptoms*** |  |
| Headache on top of the head |  |
| Feeling cold all over the body |  |
| Cold lower abdomen |  |
| Palpitation |  |
| Very cold hands up to the elbows |  |
| Very cold feet up to the knees |  |
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