



New Earth Acupuncture & Nutritional Wellness, LLC
Monica A. Judge, L.Ac., M.S.O.M., B.S. Nutrition

Wellness Center

Greendale

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. Please 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 and 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 from 1-10 the severity of the condition (1 = no symptoms, 10 = worst ever) 1 ----- ----- 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		YOU	your	FAMILY
Cancer	<input type="checkbox"/>		<input type="checkbox"/>	Herpes	<input type="checkbox"/>		<input type="checkbox"/>
-type(s)_____				AIDS/HIV	<input type="checkbox"/>		<input type="checkbox"/>
Diabetes	<input type="checkbox"/>		<input type="checkbox"/>	Other STD	<input type="checkbox"/>		<input type="checkbox"/>
Hepatitis (A, B, C)	<input type="checkbox"/>		<input type="checkbox"/>	- type(s)_____			
High Blood Pressure	<input type="checkbox"/>		<input type="checkbox"/>	Rheumatic Fever	<input type="checkbox"/>		<input type="checkbox"/>
Heart Disease	<input type="checkbox"/>		<input type="checkbox"/>	Alcoholism	<input type="checkbox"/>		<input type="checkbox"/>
Stroke	<input type="checkbox"/>		<input type="checkbox"/>	Allergies	<input type="checkbox"/>		<input type="checkbox"/>
Seizure disorder	<input type="checkbox"/>		<input type="checkbox"/>	- type(s)_____			
Thyroid Disease	<input type="checkbox"/>		<input type="checkbox"/>	Mental illness	<input type="checkbox"/>		<input type="checkbox"/>
Asthma	<input type="checkbox"/>		<input type="checkbox"/>	- type(s)_____			
osteoporosis	<input type="checkbox"/>		<input type="checkbox"/>	Kidney disease	<input type="checkbox"/>		<input type="checkbox"/>
Notes:				Anemia	<input type="checkbox"/>		<input type="checkbox"/>
				Notes:			

<p><u>Exercise</u></p> <p>Do you exercise regularly? <input type="checkbox"/> Y <input type="checkbox"/> N If yes, what and how often?</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>Do you enjoy the exercise you perform <input type="checkbox"/> Y <input type="checkbox"/> N</p>	<p><u>Habits</u></p> <table style="width: 100%; border: none;"> <tr> <td style="width: 60%;"></td> <td style="text-align: center;">Amount/Week</td> <td style="text-align: center;">If quit, year?</td> </tr> <tr> <td>Coffee/Tea _____</td> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> </tr> <tr> <td>Soda _____</td> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> </tr> <tr> <td>Tobacco _____</td> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> </tr> <tr> <td>Alcohol _____</td> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> </tr> <tr> <td>Drugs _____</td> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> </tr> </table>		Amount/Week	If quit, year?	Coffee/Tea _____	_____	_____	Soda _____	_____	_____	Tobacco _____	_____	_____	Alcohol _____	_____	_____	Drugs _____	_____	_____
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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

<p>MEDICAL CONDITIONS Please list conditions & surgeries you have or have had and year diagnosed.</p>	<p>ALLERGIES Medications, Seasonal, Environmental, Food</p>	<p>OCCUPATIONAL CONCERNS Check (✓) if your work exposes you to the following.</p>
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Year	Condition/Surgery/Injury		Occupation:
			<input type="checkbox"/> Stress
			<input type="checkbox"/> Heavy Typing/Computer Use
			<input type="checkbox"/> Hazardous Substances
			<input type="checkbox"/> Heavy Lifting
			<input type="checkbox"/> 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.

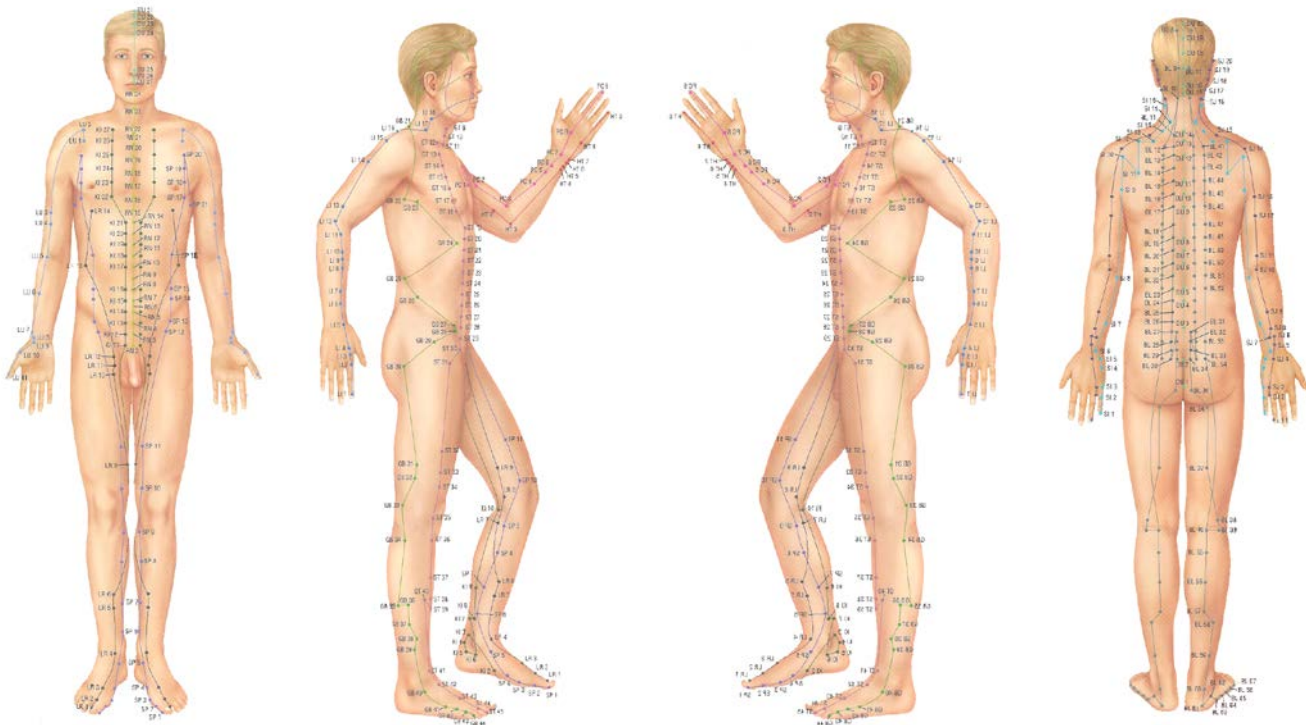
Prescription Name	Purpose	How Long	Dose	How Often	Last Dose

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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
 stabbing radiating other _____

Additional information including date of onset & cause:

<u>REPRODUCTIVE</u>	<u>URINARY</u>
<input type="checkbox"/> Change in sex drive <input type="checkbox"/> Genital pain <input type="checkbox"/> Erectile dysfunction <input type="checkbox"/> Jock itch <input type="checkbox"/> Premature ejaculation <input type="checkbox"/> Vasectomy <input type="checkbox"/> Sores on genitals <input type="checkbox"/> Hernia <input type="checkbox"/> Discharge <input type="checkbox"/> Hemorrhoids <input type="checkbox"/> Prostate disease	Fluid in = fluid out? Y/N <input type="checkbox"/> Decrease in flow <input type="checkbox"/> Pain with urination <input type="checkbox"/> Dribbling <input type="checkbox"/> Urgency to urinate <input type="checkbox"/> Difficulty starting/stopping <input type="checkbox"/> Incontinence <input type="checkbox"/> Burning urination <input type="checkbox"/> Kidney stones <input type="checkbox"/> Cloudy urine <input type="checkbox"/> Frequent urination <input type="checkbox"/> Blood in urine

Symptom Survey

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

TEMPERATURE

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

COLD |-----|-----| WARM

<input type="checkbox"/> Cold hands/feet <input type="checkbox"/> Chills <input type="checkbox"/> Cold "in the bones" <input type="checkbox"/> Areas of numbness Thirst for cold/hot drinks (circle) <input type="checkbox"/> Absence of thirst	<input type="checkbox"/> Excessive thirst <input type="checkbox"/> Night sweats <input type="checkbox"/> Unusual sweats -when am/pm -where on body _____ <input type="checkbox"/> Thirst, but no desire to drink	<input type="checkbox"/> Hot hands, feet, chest <input type="checkbox"/> Hot flashes <input type="checkbox"/> Hot in afternoon <input type="checkbox"/> Hot at night
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MOISTURE

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

DRY |-----|-----| OILY

<input type="checkbox"/> Dry skin <input type="checkbox"/> Dry eyes <input type="checkbox"/> Dry, brittle nails <input type="checkbox"/> Dry mouth <input type="checkbox"/> Dry lips	<input type="checkbox"/> Dry throat <input type="checkbox"/> Dry nose/nosebleeds <input type="checkbox"/> Edema/swelling <input type="checkbox"/> Rashes <input type="checkbox"/> Itching	<input type="checkbox"/> Dandruff <input type="checkbox"/> Oily skin <input type="checkbox"/> Oily hair <input type="checkbox"/> Pimples <input type="checkbox"/> Weight gain/loss
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DIGESTION

DIARRHEA**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****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.? Yes No

Any health problems when abroad? Yes No

What? _____