ADVANCED HEALTH & PAIN RELIEF CENTER, P.A.
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QUESTIONS FOR PATIENTS RECEIVING ACUPUNCTURE

Cold and Hot *Recently have you:*

1. Had a fever (temperature)? Yes/No
2. Had chills (shivering)? Yes/No
3. Felt cold and wanted to keep warm? Yes/No
4. Had chills and a fever together? Yes/No

Sweating *Recently:*

5. Do you sweat more profusely than normal? Yes/No
6. Do you feel sweaty most of the time? Yes/No
7. Do you suddenly break out in sweat? Yes/No
8. Are you very sweaty at night? Yes/No

Appetite, Thirst And Taste *Recently:*

9. Is your appetite better or worse than normal? *Please circle as appropriate*
10. Are you more often thirsty than you were? Yes/No
11. Do you crave certain foods? Yes/No
12. Do you particularly dislike certain foods? Yes/No
13. Do you have a bitter/sour taste in your mouth? *Please circle as appropriate*
14. Is your mouth more often dry than it was? Yes/No
15. Is your mouth more often very sticky? Yes/No

Stools And Urine

16. Are you constipated? Yes/No
17. Are your stools loose/watery/bloodstreaked? *Please circle as appropriate*
18. Is your urine clear/light yellow/dark yellow/light red? *Please circle as appropriate*
19. Do you dribble urine occasionally? Yes/No

Pain

19. Does your pain move from one part of the body to another? Yes/No
20. Is your pain of sharp or pricking nature? Yes/No
21. Do you have pain with a heavy feeling in the body? Yes/No
22. Do you have pain with muscle spasm? Yes/No
23. Is your pain burning/cold/dull (in nature)? *Please circle as appropriate*

Sleep *Recently:*

24. Do you sleep well through the whole night? Yes/No
25. Do you have poor sleep and dizziness during the night? Yes/No
26. Is your sleep disturbed, do you wake up several times? Yes/No
27. Do you have difficulty falling asleep, but eventually sleep through? Yes/No