Acupuncture Health History

Please complete this health history evaluation as thoroughly as desired, using the back of the pages as needed or give additional information in your personal interview and assessment. *All of your responses are confidential.* Feel free to ask questions. Thank you.

Name_____ Today's date: _____

Street_____City_____ State_____ ZIP_____

Home Phone _____Cell Phone_____

Email address_____ best method to contact you _____

May I have your permission to contact you via phone, text or email? □ Yes_____ □ No_____

Date of Birth_____ Height_____ Weight_____

Marital Status: _____ Occupation:_____ Education:_____

Referred by: _____Relation to you: _____

Primary Care Physician: _____

Other Health Care Practitioners: _____

Emergency Contact: _____Emergency Contact telephone: _____

Reason for seeking treatment: _____

_____

How long ago did this issue begin? Please be specific: _____

_____

Have you been given a diagnosis for this problem? Yes ___ no___
If so, what diagnosis and by whom? _____

What makes your condition better? _____

What makes it worse? _____

What other kinds of treatment have you tried? □ Western Medicine □ Acupuncture □ Herbs □ Massage
□ Physical Therapy □ Chiropractor □ Reiki □ Homeopathy □ Other: _____

Past Personal Medical History:

Major Illnesses, Surgeries, Anesthesias (including dates):_____

_____

Significant Trauma, Loss of Consciousness (auto accidents, falls, etc.): _____

_____

Allergies (drugs, chemicals, foods, metals):_____

Current Medicines and Supplements: Please list all (use other side of page if needed)

_____

_____

Have you ever taken Antibiotics, Steroids, Chemotherapy or received Radiation treatments?

Please give detail (use other side if needed) _____

Do you have a regular exercise or movement practice? □ No □ Yes (describe)_____

Do you have a regular meditation practice? (describe)_____

Do you have a specific nutritional plan? (describe) _____

Do you smoke? □ No □ Yes If Yes, how many cigarettes or cigars per day? _____

How many cups of caffeinated coffee, tea, or cola do you drink per day? _____

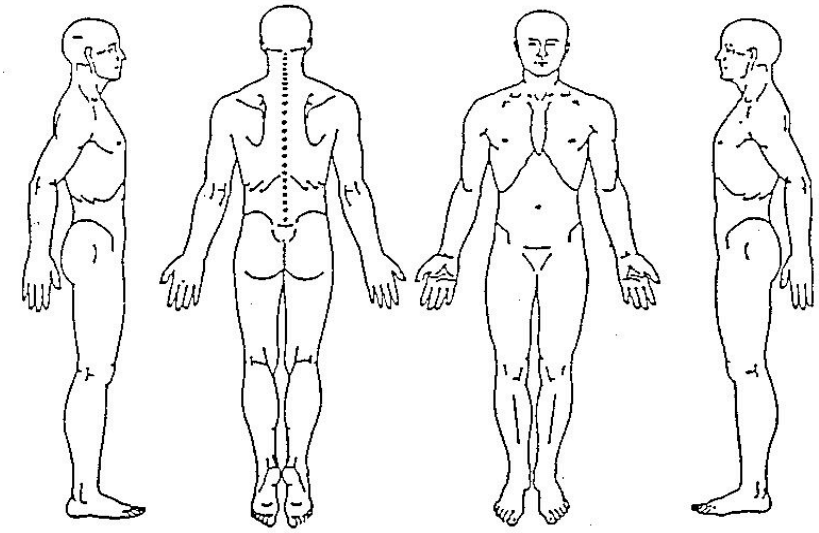
How many 8 oz. glasses of water do you drink per day? _____

How many alcoholic beverages do you drink per week? _____

Please describe any use of drugs for non-medical purposes: _____

Please indicate any painful or distressed body areas by marking the area on the diagram below:

MUSCULOSKELETAL:



Please check if you have had any of the following, particularly in the recent past:

□ Neck pain □ Shoulder Pain □ Rotator cuff □ Hand/Wrist Pain
□ Carpal tunnel □ Hip pain □ Knee pain □ Sciatica
□ Foot/ankle pain □ Muscle pain □ Muscle weakness □ Strains/sprains
□ Tendonitis □ Bursitis
□ Soreness/weakness of *lower body* (back, hip, knee, ankle, foot)
□ Back pain: Low____ Middle_____ Upper_____

General: (describe the following)

Sleep _____

Energy _____

Stress _____

Digestion _____

Please check if you have or have had any of the issues listed: (add comments as desired)

General:

□ Change in appetite □Poor Appetite □ Weight loss □ Weight gain
□ Fevers □ Chills □ Night sweats □ Sweat easily
□ Bleed or bruise easily □ Cravings/Aversions □ Strong thirst for hot drinks or cold drinks

Skin and Hair

□ Rashes □ Eczema/Psoriasis □ Skin discoloration □ Dermatitis
□ Ulcerations □ Dandruff □ Acne □ Warts
□ Itching □ Hives/Allergic Dermatitis □ Loss of hair □ Change in skin/hair texture
□ Fungal Infection □ Recent moles □ Weak / ridged nails

Head, Eyes, Ears, Nose and Throat

□ Face flushing □ Eye pain □ Eye Strain □ Cataracts
□ Dizziness □ Poor vision □ Blurred vision □ Color Blindness
□ Glasses □ Night Blindness □ Spots in front of eyes □ Migraines/headaches
□ Poor hearing □ Ringing in ears □ Facial pain □ Sinus problems
□ Nose bleeds □ Grinding teeth □ Jaw clicks/locks □ gum problems
□ Peculiar tastes/smells □ Recurrent sore throats/colds □ Earaches

Cardiovascular

□ Chest pain or pressure □ Shortness of breath □ Irregular heart beat □ Palpitations at rest
□ Fainting □ Dizziness □ High blood pressure □ Low blood pressure
□ Swelling of hands/feet □ Varicose/spider veins □ Cold hands/feet □ Blood clots
□ Phlebitis

Respiratory

□ Cough/Wheezing □ Difficult breathing □ Difficult breathing lying down □ Pain with deep inhalation
□ Pneumonia □ Bronchitis □ Asthma □ Tight sensation in chest
□ Coughing blood □ Production of phlegm... what color? _____

Gastrointestinal

□ Nausea □ Vomiting □ Gas/ Belching □ Indigestion
□ Bloating/Edema □ Black or bloody stool □ Hemorrhoids □ Abdominal pain/cramps
□ Bad breath □ Constipation □ laxative use □ Acid reflux/GERD
□ Diarrhea/loose stools □ Rectal pain □ Hernia □ IBS/Crohn's Disease

Genito-Urinary

□ Pain on urination □ Frequent urination □ Urinary tract infection □ Unable to hold urine
□ Kidney stones □ Blood in urine □ Copious or scanty urine □ Urgent urination
□ Pain in urinary tract or genital regions □ Prostatitis

Gynecological/Reproductive

□ Date of last menses_____ □ Painful periods □ Heavy menstrual flow □ clots with menses
□ PMS □ Ovarian cysts □ Endometriosis □ Date of last PAP _____
□ Polycystic Ovarian Disease □ PMS

Have you had any Pregnancies, miscarriages and/or births? (details) _____

_____

Do you practice birth control?_____ What type?_____ For how long?_____

Neuropsychological

□ Loss of balance □ Poor memory □ Concussion □ Easily susceptible to stress
□ Bipolar symptoms □ Seizures □ Lack of coordination □ Bad temper/irritable
□ Vertigo/Dizziness □ Depression □ Seasonal Affective Disorder □ Post Traumatic Stress
□ Anxiety/Panic attacks □ Nervousness □ Areas of numbness □ Tremors
□ ADD/ADHD
□ Have you ever been treated for emotional distress? Yes____ No____
□ Have you ever been treated for addiction or withdrawal? Yes____ No____

Family Medical History

Please check any condition that applies to your immediate family.
Put an F (father), M (mother), S (sister), B (brother), GM (grandmother), GF (grandfather) next to issue.

Diabetes ___ Seizures ___ Heart Disease ___ Stroke ___ Hypertension__ Allergies ___ Cancer ___ Asthma __

Other_____

Comments: _____

_____

_____

_____

_____

_____

_____

_____