WELCOME!
All information provided here is held in strictest confidence.

Patient's Health History Form

1. IDENTIFYING INFORMATION: **Today's Date______/______/______**

Last Name______________________________ First Name_________________________ Middle Initial____

DOB_____/_____/_____ Age_________ Sex ☐ Male ☐ Female **Marital Status** ☐ S ☐ M ☐ W

Address____

City_________________ State ______ Zip__________ Email____

Cell Phone _____________________ Home Phone __________________ Work Phone _____________________

Employer: _________________________ Occupation: ______________________ Do you like your work? ___

Emergency Contact: Name_____________________________________ Phone_________________________

Primary Care MD: ___________________________________ Phone: ________________________________

Referred By______________________________________ Have you had acupuncture before? ☐ **Yes** ☐ **No**

Would like to receive: our Monthly Newsletter ☐ **Health Classes schedule** ☐

Insurance Company____________________________ Do they cover acupuncture? ☐ **Yes** ☐ **No** ☐ **Not Sure**

Please provide us with your insurance information and/or card and we will verify if you have benefits.

2. CURRENT MEDICAL CONCERNS:

Reasons for coming to see us:

1. ____ When did it start? ___________________

2. ____ When did it start? ___________________

3. ____ When did it start? ___________________

4. ____ When did it start? ___________________

5. ____ When did it start? ___________________

If pain what is your pain level (circle): low - 0 1 2 3 4 5 6 7 8 9 10 - high

Have you been given a diagnosis for this problem? If yes, what? ____

What makes it better? ____

What makes it worse? ____

3. MEDICATIONS: Include prescriptions, over-the-counter drugs, vitamins, & supplements used during the past year.

	Medication/supplement	Start Date	End Date	Dose	Reason
1.					
2.					
3.					
4.					
5.					
6.					
7.					

4. INJURIES, OPERATIONS & HOSPITALIZATIONS: Please start with most recent.

	Description	Date	Physician	Current Status
1.				
2.				
3.				
4.				

5. ALLERGIES:

	Drug or Substance	When	Reaction
1.			
2.			
3.			

6. MEDICAL CONDITIONS/HISTORY: Do you have or have you had?

- ☐ Cancer
- ☐ Diabetes
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Rheumatic Fever
- ☐ Mitral Valve Prolapse
- ☐ Scarlet Fever
- ☐ Seizures
- ☐ Asthma
- ☐ Allergies
- ☐ Pneumonia
- ☐ Bronchitis
- ☐ Emphysema
- ☐ Anemia
- ☐ Stroke
- ☐ Bleeding Disorder
- ☐ Blood Transfusion
- ☐ Blood Clots
- ☐ Kidney Disorder
- ☐ Rubella
- ☐ Tuberculosis
- ☐ Chicken Pox/Shingles
- ☐ Mumps
- ☐ Mononucleosis
- ☐ Recent Immunization
- ☐ Autoimmune Disease
- ☐ Thyroid Disorder
- ☐ Genetic/Inherited Disorder
- ☐ Psychiatric Disorder
- ☐ Hepatitis/Liver Disorder
- ☐ Gall Bladder Problems
- ☐ Alcoholism/Drug Abuse
- ☐ Digestive Disorder
- ☐ Ulcers
- ☐ Colitis/Enteritis
- ☐ Arthritis
- ☐ Serious Injury/Accident
- ☐ STDs
- ☐ HIV/AIDS

Please explain any above conditions/injuries____

____

____

7. DIET & LIFESTYLE:

Appetite: ☐ Low ☐ High   Energy drop after meals: ☐ Yes ☐ No

Vegetarian: ☐ Yes ☐ No   Do you eat a lot of spicy food? ☐ Yes ☐ No

Are you satisfied with your nutrition? ☐ Yes ☐ No Describe your average daily diet:

Breakfast:

Lunch:

Dinner:

Snacks:

☐ Caffeine (# drinks per day) ______   ☐ Sugar/Sweetener   ☐ Alcohol (# drinks per week) ______

☐ Tobacco (# per day) _____   ☐ Marijuana   ☐ Drugs for non-medical purposes _________________________

Do you exercise regularly ☐ Yes ☐ No   Describe exercise program: _________________________________

How many hours do you sleep in general? _____ When do you usually go to bed? ________ Wake up? _________

Wake feeling rested? ☐ Yes ☐ No

Height ______   Weight now ______ One year ago _____ Weight maximum ______ @ Year _______

Are you at your ideal weight? ☐ Yes ☐ No   What weigtht do you think is ideal for you? _________________

Please describe what stress you and your response to stress:

____

____

8. FAMILY HISTORY: Do any of your blood relatives have or had (indicate which relative – i.e. father, mother, sister)?

☐ **Cancer**________________________ ☐ **Diabetes**___________________ ☐ **High Cholesterol**_______________ ☐ **High Blood Pressure**____________ ☐ **Heart Disease**_____________ ☐ **Stroke** ________________________

☐ **Asthma** ________________________ ☐ **Alcoholism**________________ ☐ **Blood Clotting** ________________

☐ **Thyroid Disorder** _________________________**Other**____

9. WOMEN'S HEALTH: Men skip to section 10.

Age of first period_____ **Start date of last period**_____/_____/_____

Are your periods regular? ☐ Yes ☐ No **Do you bleed between periods?** ☐ Yes ☐ No

Duration of periods_____ **days, cycle length** _____ **days** **# pads/tampons used on heaviest days** _______

Last Pap Smear_____/_____/_____ **Last Mammogram**_____/_____/_____

Times Pregnant____ **Premature Births**____ **Term Births**____ **Miscarriages**___ **Cesareans**____ **Abortions** ____

Please explain any complications during pregnancy, delivery, or postpartum____________________________

____

Did your child have any birth defects or inherited disorders? ☐ Yes ☐ No **If yes, please explain**____

Did you receive infertility treatment for any of your pregnancies? ☐ Yes ☐ No **If yes, please indicate the type of treatment**____

Do you have or have you had?

☐ Fibroids ☐ Pelvic Infections ☐ Menstrual Mood Changes ☐ Breast Tenderness
☐ Breast Cysts ☐ Hot Flashes ☐ Frequent Vaginal Infections ☐ Menstrual Bloating
☐ Menstrual Clots ☐ Irregular Periods ☐ Fertility Problems ☐ Breast Discharge
☐ Endometriosis ☐ Ovarian Cysts ☐ Breast Implants ☐ Excessive Vaginal Discharge
☐ Low Libido ☐ Excessive Libido ☐ Pelvic Pain with Intercourse ☐ Vaginal Dryness

Do you experience pelvic pain or cramps?

☐ None ☐ Before Menses ☐ During Menses ☐ After Menses ☐ Midcycle

Is there a family history of any of the following?

☐ Miscarriage ☐ Premature Menopause ☐ Endometriosis ☐ Uterine Fibroids ☐ Infertility

If yes, please explain____

Contraceptive Use: Please start with most recent.

	Type	From When to When	Reason Discontinued
1.			
2.			
3.			

10. MEN'S HEALTH: Do you have or have you had? Women skip to section 11.

☐ Impotence ☐ Fertility Problems ☐ Ejaculation Problems ☐ Frequent Seminal Emission
☐ Discharge ☐ Prostate Problems ☐ Painful/Swollen Testicles

11. SYSTEMIC REVIEW: Do you have or have you had any of the following in the past three months.

General

☐ Night Sweats	☐ Chills	☐ Bleed/Bruise Easily	☐ Desire Cold Food/Drink
☐ Poor Balance	☐ Fatigue	☐ Localized Weakness	☐ Desire Hot Food/Drink
☐ Peculiar Tastes	☐ Cravings	☐ Weight Loss	☐ Poor Sleep
☐ Sweat Easily	☐ Fever	☐ Weight Gain	

☐ Energy Drop, What time of day? _____________ Favorite Season _____________ Worst Season _____________

Skin & Hair

☐ Rashes	☐ Acne	☐ Ulcerations	☐ Hives
☐ Itching	☐ Eczema	☐ Dandruff`	☐ Dry Skin
☐ Purpura	☐ Hair Loss	☐ Mole Changes	☐ Dry Hair
☐ Change in Hair/Skin	☐ Skin Cancer	☐ Warts	

Musculoskeletal

☐ Joint Disorders	☐ Weak Muscles	☐ Numbness	☐ Tingling
☐ Paralysis	☐ Cold Hands/Feet	☐ Swelling Hands/Feet	☐ Walking Difficulty
☐ Sore Muscles	☐ Tremors	☐ Hand/Wrist Pain	☐ Elbow Pain
☐ Shoulder Pain	☐ Ankle Pain	☐ Knee Pain	☐ Hip Pain
☐ Back Pain	☐ Spinal Disorder	☐ Disc Hernia	☐ Neck Pain/Tightness

Head, Ears, Eyes, Nose, Throat

☐ Eye Pain	☐ Eye Strain	☐ Cataracts	☐ Night Blindness
☐ Vision Correction	☐ Color Blindness	☐ Blurry Vision	☐ Recent Vision Changes
☐ See Floaters/Spots	☐ Ringing in Ears	☐ Poor Hearing	☐ Earaches
☐ Sinus Problems	☐ Nose Bleeds	☐ Dizziness	☐ Head Injury/Trauma
☐ Sore Throat	☐ Teeth Problems	☐ Grinding Teeth	☐ Jaw Clicks
☐ Facial Pain	☐ Lip/Tongue Sores	☐ Difficulty Swallowing	☐ Bad Breath

☐ Headaches, Location_________________ Frequency_________________ ☐ Excessive Saliva

Gastrointestinal

☐ Poor Appetite	☐ Nausea	☐ Vomiting	☐ Change in Appetite
☐ Indigestion	☐ Belching	☐ Gas	☐ Bloating
☐ Diarrhea	☐ Constipation	☐ Black Stools	☐ Blood/mucous in Stools
☐ Rectal Pain	☐ Hemorrhoids	☐ Parasites	☐ Gallbladder Problems
☐ Abdominal Pain/Cramps		☐ Laxative Use	☐ Acid Reflux

# of Bowel Movements Per Day _____ ☐ Alternating Constipation/Diarrhea

Genito-Urinary

☐ Pain on Urination	☐ Blood in Urine	☐ Frequent Urination	☐ Urgent Urination
☐ Kidney Stones	☐ Dribbling	☐ Pause of Flow	☐ Urinary Tract Infection
☐ Genital Pain	☐ Genital Itching	☐ Unable to Hold Urine	

Cardiovascular

☐ Chest Pain	☐ Palpitations	☐ Fainting	☐ Irregular Heartbeat
☐ Phlebitis	☐ Rapid Heartbeat	☐ Varicose Veins	☐ High Blood Pressure
☐ Low Blood Pressure	☐ Pacemaker, since what year ________		

Respiratory

☐ Cough	☐ Wheezing	☐ Coughing Blood	☐ Difficulty Breathing
☐ Bronchitis	☐ Pneumonia	☐ Heaviness of Chest	☐ Shortness of Breath

☐ Shallow Breathing ☐ Production of Phlegm, Color _________, Time of day __________

Neuro-Psychological

☐ Depression	☐ Anxiety	☐ Stress, Easily stressed	☐ Bad Temper
☐ Bi-Polar	☐ Loss of Balance	☐ Lack of Coordination	☐ ADD
☐ Abuse Survivor	☐ Poor Memory	☐ Irritability	☐ Seeing a Therapist

Anything else you would like us to know? ____

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