HEALTH HISTORY

Name: _____ **Date:** _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Home Phone: _____ **Work Phone:** _____

Mobile Phone: _____ **E-Mail:** _____

Date of Birth: _____ **Age:** _____ **Marital Status:** _____

Referred by: _____ **Occupation:** _____

In Emergency Notify: _____ **Phone:** _____

Main Complaint (symptoms, diagnosis, duration, etc.)

Significant Trauma (physical or emotional)

_____

Birth History (prolonged labor, forceps delivery, complications, etc.)

Surgeries (please include date of procedure)

Allergies (chemical, environmental, food, drugs, etc.)

Medications (names & dosages) Please attach an additional page if necessary.

Vitamins/Supplements/Herbs

Exercise
Days per week **Length of workout** **Type of Activity**

Diet
Meals per day **Snacks** **Caffeinated Drinks** **Alcohol per week**

What makes your condition better? (Rest, movement, heat, cold, fresh air, eating, crying, etc.)

What makes your condition worse? (stress, fatigue, hunger, heat, certain foods, damp days etc.)

Personal History

Please check any conditions or symptoms you have now.

- ☐ Arthritis
- ☐ High/Low Blood Pressure
- ☐ Cancer
- ☐ Ulcer
- ☐ Chronic Fatigue
- ☐ Alcoholism
- ☐ Gastritis/Pancreatitis
- ☐ Liver/Gall Bladder Disease
- ☐ Hypo/Hyperglycemia
- ☐ Diabetes
- ☐ Seizures
- ☐ Anemia
- ☐ Lyme Disease
- ☐ Asthma
- ☐ Stroke
- ☐ Kidney Disease
- ☐ Food Allergies/Intolerance
- ☐ Hepatitis ☐ Raynaud's Disease
- ☐ Thyroid Imbalance
- ☐ Chronic Pain Condition
- ☐ Infertility ☐ Emphysema
- ☐ Heart Disease
- ☐ Elevated Blood Cholesterol
- ☐ Diverticulitis/IBS
- ☐ Respiratory Allergies
- ☐ Impotence

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 choice.

- ☐ Diabetes ___
- ☐ High Blood Pressure ___
- ☐ Seizures ___
- ☐ Allergies ___
- ☐ Heart Disease ___
- ☐ Cancer ___
- ☐ Stroke ___
- ☐ Asthma ___
- ☐ Other_____

Please check if you have had any of these items listed below in the last year
Put a star on the box if you had this in the past but do not any longer.

General

- ☐ Poor Appetite
- ☐ Chills
- ☐ Cravings
- ☐ Bleed/Bruise easily
- ☐ Muscle weakness/fatigue
- ☐ Poor Sleeping
- ☐ Night Sweats
- ☐ Localized Weakness
- ☐ Weight loss/gain
- ☐ Sudden energy drop
- ☐ Fatigue
- ☐ Sweats Easily
- ☐ Poor Balance
- ☐ Peculiar tastes/smells
- ☐ Strong thirst (hot or cold drinks)
- ☐ Fevers
- ☐ Tremors
- ☐ Change in appetite
- ☐ Dental/gum problems

Skin and Hair

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

Head, Eyes, Ears, Nose and Throat

- ☐ Dizziness
- ☐ Eye Strain
- ☐ Color Blindness
- ☐ Ringing in ears
- ☐ Nose bleeds
- ☐ Sores on lips/tongue
- ☐ Difficulty swallowing
- ☐ Eye pain
- ☐ Cataracts
- ☐ Poor hearing
- ☐ Recurrent sore throats/colds
- ☐ Dental problems
- ☐ Migraines
- ☐ Poor vision
- ☐ Blurred vision
- ☐ Spots in front of eyes
- ☐ Grinding teeth
- ☐ Jaw clicks/locks
- ☐ Glasses
- ☐ Night Blindness
- ☐ Earaches
- ☐ Sinus problems
- ☐ Facial pain
- ☐ Headaches

Cardiovascular

- ☐ Chest pain or pressure
- ☐ Cold hands/feet
- ☐ Shortness of breath
- ☐ Low blood pressure
- ☐ Irregular heart beat
- ☐ Swelling of hands/feet
- ☐ Varicose/spider veins
- ☐ Spontaneous sweating
- ☐ Palpitations at rest
- ☐ Blood clots
- ☐ Pressure in chest
- ☐ Dizziness
- ☐ Fainting
- ☐ Phlebitis
- ☐ High blood pressure

Respiratory

- ☐ Cough/Wheezing
- ☐ Pneumonia
- ☐ Difficulty breathing when lying down
- ☐ Coughing blood
- ☐ Pain with deep inhalation
- ☐ Asthma
- ☐ Tight sensation in chest
- ☐ Production of phlegm… what color? _____
- ☐ Bronchitis
- ☐ Difficult inhale/exhale

Gastrointestinal

- ☐ Nausea
- ☐ Gas
- ☐ Indigestion
- ☐ Bloating/Edema
- ☐ Changes in appetite
- ☐ Excessive appetite
- ☐ Vomiting
- ☐ Belching
- ☐ Bad breath
- ☐ Chronic laxative use
- ☐ Acid reflux/GERD
- ☐ Significant thirst
- ☐ Diarrhea
- ☐ Black stools
- ☐ Rectal pain
- ☐ Loose stools (>2 per day)
- ☐ Hernia
- ☐ IBS/Crohn's Disease
- ☐ Constipation
- ☐ Blood in stool
- ☐ Hemorrhoids
- ☐ Abdominal pain/cramps
- ☐ Poor appetite

Genito-Urinary

- ☐ Pain on urination
- ☐ Unable to hold urine
- ☐ Impotence
- ☐ Frequent urination
- ☐ Kidney stones
- ☐ Sores on genitals
- ☐ Blood in urine
- ☐ Scanty flow
- ☐ Urinary tract infection
- ☐ Urgent urination
- ☐ Copious flow
- ☐ Burning urination

☐**Premature ejaculation** ☐**Decreased libido** ☐**Prostatitis** ☐**Dribbling after urination**
☐**Nocturnal emission** ☐**Pain in testicles** ☐**Herpes** ☐**Infections**
☐**Night urination… What time?_____ How often?_____** ☐**Excessive libido**

Gynecological/Reproductive

☐**Difficult/Painful intercourse**
☐**Vaginal dryness**
☐**Vaginal sores**
☐**Vaginal discharge**
☐**Infertility**
☐**Irregular menstruation**

☐**Ovarian cysts**
☐**Endometriosis**
☐**Uterine Fibroids**
☐**Fibrocystic breast tissue**
☐**Polycystic Ovarian Disease**
☐**PMS**
☐**Painful menstruation**

☐**Age of first menses_____**
☐**Date of last menses_____**
☐**Date of last PAP/Pelvic_____**
☐**Number of pregnancies____**
☐**Number of ectopic pregancies_____**
☐**Number of live births_____**
☐**Number of miscarriages_____**
☐**Number of abortions_____**

Do you practice birth control?_____
What type?_____ How long?_____

Musculoskeletal

☐**Neck pain** ☐**Shoulder pain** ☐**Hand/wrist pain** ☐**Carpal Tunnel**
☐**Knee pain** ☐**Sprains/Strains** ☐**Sciatica** ☐**Foot/ankle pain**
☐**Hip pain** ☐**Muscle pain** ☐**Muscle weakness** ☐**Tendonitis**
☐**Back pain Low___ Middle___ Upper___** ☐**Bursitis** ☐**Rotator Cuff**
☐**Soreness weakness in lower body (back, knee, hip, ankle, foot)/**

Neuropsychological

☐**Seizures** ☐**Loss of balance** ☐**Vertigo/Dizziness** ☐**Areas of numbness**
☐**Lack of coordination** ☐**Poor memory** ☐**Concussion** ☐**Depression**
☐**Anxiety/Panic attacks** ☐**Bad temper/irritable** ☐**Easily susceptible to stress** ☐**Seasonal Affective Disorder**
☐**Nervousness** ☐**ADD/ADHD** ☐**Manic Depression**

Have you ever been treated for emotional problems? ☐**Yes** ☐**No**
Have you ever considered or attempted suicide? ☐**Yes** ☐**No**
Have you ever been treated for substance abuse? ☐**Yes** ☐**No**

Comments **Please inform me of any other problems you would like to discuss.**

Acupuncture Consent to Treatment

I hereby request and consent to the performance of acupuncture treatments and other Oriental medicine procedures on me (or on the patient named below, for which I am legally responsible) by the below name licensed acupuncturist.

I understand that methods or treatments may include but are not limited to acupuncture, moxibustion, cupping, bloodletting, electrical stimulation, Tui Na (Chinese massage), Gua Sha, Chinese or Western herbal medicine, and nutritional counseling.

The herbs and nutritional supplements (which are from plant, animal and mineral sources) that have been recommended are traditionally considered safe in the practice of Chinese Medicine. I understand the same herbs may be inappropriate during pregnancy and will inform my practitioner immediately of pregnancy status. If I experience any gastro-intestinal reactions to the herbs I will inform the acupuncturist immediately.

I have been informed that I have a right to refuse any form of treatment. I have read, or have had read to me the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I also understand there is always a possibility of an unexpected complication and I understand that no guarantee can be made concerning the results of treatment. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment. _____

initials

I understand it may be necessary for my practitioner to contact another one of my health care providers in order to coordinate medical treatment, to discuss an emergency situation and/or to share appropriate medical information. My signature gives my practitioner permission to release my medical records for the reasons listed above. _____

initials

_____

Patient's Name

_____

Patient's Signature

_____

Date Signed

_____

Are you Pregnant?

_____

Name of Licensed Acupuncturist

To be completed by the patient's representative, if the patient is a minor, or physically/legally incapacitated.

Name of Patient_____

Patient's Representative_____

Relationship or Authority of Patient_____

Witness_____

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