Acupuncture Health History Form

Patient Information

Name _____ Date _____

Address _____

City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____

Height _____ Weight _____ Sex: ☐ Male ☐ Female Marital Status _____

Date of Birth _____ Age _____

Occupation _____ Employer _____

Have you had acupuncture before? ☐ No ☐ Yes, Name of Acupuncturist _____

Major Complaint

Primary reason for your visit today? _____

_____

Has this condition been diagnosed by a physician, or other provider?

☐ No ☐ Yes, Diagnoses _____

Are you being treated for this condition by anyone else? ☐ Yes ☐ No

If yes, what is the treatment? _____

Have these treatments helped? ☐ Yes ☐ Somewhat ☐ Not Much ☐ Not At All

How does this condition affect you? _____

How long have you had this condition? _____

Personal Health History

Your general health as a child was? ☐ Excellent ☐ Good ☐ Average ☐ Poor

Did you feel safe and nurtured as a child? ☐ Always ☐ Usually ☐ Sometimes ☐ Never

Check all the illnesses or conditions which <u>you</u> currently have or have had in the past:

☐ AIDs / HIV	☐ Eating Disorders	☐ Kidney Disease	☐ Rheumatic Fever
☐ Alcoholism	☐ Epilepsy	☐ Measles	☐ Scarlet Fever
☐ Allergies	☐ Glaucoma	☐ Meningitis	☐ Sexually Transmitted Disease
☐ Antibiotic Use	☐ Heart Disease	☐ Mental Illness	
☐ Asthma	☐ Hepatitis	☐ Multiple Sclerosis	☐ Stroke
☐ Bleed Easily	☐ High Blood Pressure	☐ Mumps	☐ Tuberculosis
☐ Cancer	☐ High Fevers	☐ Obesity	☐ Typhoid Fever
☐ Chicken Pox	☐ Hyperthyroid	☐ Pneumonia	☐ Ulcers
☐ Diabetes	☐ Hypothyroid	☐ Polio	☐ Vascular Disease
☐ Drug Abuse	☐ Jaundice	☐ Other _____	

Are you taking Coumadin or Warfarin? ☐ Yes ☐ No

Do you have a pacemaker? ☐ Yes ☐ No Do you have seizures? ☐ Yes ☐ No

Do you currently have any infectious diseases? ☐ Yes ☐ No ☐ Possibly

If yes, please identify: ☐ HIV / AIDs ☐ Hepatitis B ☐ Hepatitis C ☐ Flu / Cold ☐ Streptococcus ☐ Mononucleosis ☐ Tuberculosis ☐ Other _____

Known or suspected allergies: _____

Personal Health Inventory

Please put a check mark (✔)by the symptoms that you have now.
Place a star (✳) next to the ones you have noticed within the last three months.

Qi, Blood, Yin, Yang

- ☐ anxiety
- ☐ catches colds easily or frequently
- ☐ chest pain traveling to shoulder
- ☐ cold feet
- ☐ cold hands
- ☐ difficult to concentrate
- ☐ dizziness
- ☐ dream disturbed sleep
- ☐ dry skin
- ☐ fatigue
- ☐ feverish in the afternoon or flushes
- ☐ general weakness
- ☐ heat sensations in hands, feet, chest
- ☐ insomnia
- ☐ mental confusion
- ☐ night sweats
- ☐ palpitations
- ☐ restlessness
- ☐ sores on tip of tongue
- ☐ speech problems
- ☐ sweats easily
- ☐ thirst, at night
- ☐ you feel worse after exercise
- ☐ you see floating black spots

LU

- ☐ allergies
- ☐ chills alternating with fever
- ☐ cough
- ☐ difficulty breathing
- ☐ dry mouth, throat, nose
- ☐ feeling achy
- ☐ headaches
- ☐ nasal discharge
- ☐ nose bleeds
- ☐ shortness of breath
- ☐ sinus congestion
- ☐ sneezing
- ☐ sore throat
- ☐ stiff neck/ shoulders

SP

- ☐ abdominal bloating and / or gas after eating
- ☐ belching
- ☐ chest congestion
- ☐ constipation
- ☐ diarrhea
- ☐ eating disorders
- ☐ fatigue after eating
- ☐ gas
- ☐ general feeling of heaviness in your body
- ☐ hemorrhoids
- ☐ loose stools
- ☐ low appetite
- ☐ mental heaviness, sluggishness or fogginess
- ☐ nausea
- ☐ prolapsed organs (previously diagnosed)
- ☐ swollen feet
- ☐ swollen hands
- ☐ you bruise easily

ST

- ☐ bad breath
- ☐ belching
- ☐ bleeding, swollen or painful gums
- ☐ burning sensation after eating
- ☐ constipation
- ☐ heartburn
- ☐ large appetite
- ☐ mouth sores (canker or cold sores)
- ☐ stomach pain
- ☐ vomiting

HT / PC

- ☐ chest pain
- ☐ edema
- ☐ high blood pressure
- ☐ insomnia
- ☐ low blood pressure
- ☐ palpitations
- ☐ stroke
- ☐ varicose veins

LR / GB

- ☐ bitter taste in mouth
- ☐ blood shot eyes
- ☐ blurred vision
- ☐ chest pain
- ☐ convulsions
- ☐ diarrhea alternating with constipation
- ☐ difficulty swallowing
- ☐ dry eyes
- ☐ feeling of a lump in your throat
- ☐ headache at the top of your head
- ☐ hot flashes
- ☐ muscle spasms, twitching, cramping
- ☐ numbness of hands and feet
- ☐ pain in rib cage
- ☐ red, sore or irritated eyes
- ☐ seizures
- ☐ skin rashes
- ☐ tight feeling in chest
- ☐ TMJ or locked jaw
- ☐ you anger easily
- ☐ you feel better after exercise

KI / BL

- ☐ frequent urination
- ☐ hair loss
- ☐ joint pain
- ☐ lack of bladder control
- ☐ loose teeth
- ☐ low back pain
- ☐ memory problems
- ☐ night blindness or low vision
- ☐ ringing in your ears
- ☐ sore, cold or weak knees
- ☐ you get up more than one time at night to urinate

Other _____

_____

_____

_____

_____

_____

Family History

How do you feel about the following areas of your life in the past month.

Significant Other ☐ Great ☐ Good ☐ Fair ☐ Poor ☐ N/A Comments _____

Family ☐ Great ☐ Good ☐ Fair ☐ Poor ☐ N/A Comments _____

Self ☐ Great ☐ Good ☐ Fair ☐ Poor Comments _____

Check illnesses which have occurred in any of your <u>blood relatives</u>:

☐ Alcoholism ☐ Cancer ☐ Heart Disease ☐ Mental Illness

☐ Allergies ☐ Diabetes ☐ High Blood Pressure ☐ Obesity

☐ Bleed Easily ☐ Epilepsy ☐ Kidney Disease ☐ Stroke

☐ Other _____

Women Only

Are you pregnant? ☐ Yes, How many months? _____ ☐ No ☐ Trying ☐ Maybe

Method of birth control? _____

Age of First Menses _____ Date of Last Menses _____ Age of Menopause _____

Typical Length of Menses (Days You Bleed) _____

Typical Length of Cycle (From the 1st Day of One Cycle to 1st Day of the Next) _____

Number of: Pregnancies _____ Births _____ Abortions _____ Miscarriages _____

Hysterectomy ☐ Yes ☐ Partial ☐ Complete Date _____ ☐ No

Check all that apply to you:

☐ Scanty Flow ☐ Painful Periods ☐ Low Libido

☐ Heavy Flow ☐ Breast Tenderness ☐ Excessive Libido

☐ Clotting ☐ Breast Lumps ☐ Painful Intercourse

☐ Vaginal Discharge ☐ Nipple Discharge ☐ Infertility

☐ Abnormal Pap Smear ☐ Fibrocystic Breasts ☐ Fibroids

☐ Menopausal Symptoms ☐ Bleeding Between Cycles ☐ Endometriosis

☐ Premenstrual Problems ☐ Irregular Cycles ☐ Ovarian Cysts

☐ Other _____

Men Only

Check all that apply to you:

☐ Low Libido ☐ Seminal Emissions ☐ Prostate Problems

☐ Excessive Libido ☐ Premature Ejaculation ☐ Testicular Pain

☐ Impotence ☐ Painful Intercourse ☐ Testicular Redness

☐ Vasectomy, Date _____ ☐ Testicular Swelling

☐ Other _____

Medications Please list medications, herbal supplements and vitamins you are currently taking:

Drug / Supplement / Vitamin	Reason For Taking	For How Long	Dosage	Frequency

Lifestyle

How would you rate the following areas of your health in the past month.

Digestion ☐ Great ☐ Good ☐ Fair ☐ Poor Comments _____

Stools ☐ Great ☐ Good ☐ Fair ☐ Poor Comments _____
How many times per day? _____ Do they feel complete? ☐ Yes ☐ No
Stool consistency? ☐ Loose ☐ Formed ☐ Hard to Pass ☐ Other _____
What is the color of your stools?_____
Is there blood in your stools? ☐ Yes ☐ No How Often? _____

Urination ☐ Great ☐ Good ☐ Fair ☐ Poor Comments _____
How many times per day? _____ What color is your urine? _____
After you've gone to sleep do you get up to urinate? ☐ Yes ☐ No How Often? _____
Is your urination painful? ☐ Yes ☐ No

Appetite ☐ Great ☐ Good ☐ Fair ☐ Poor Comments _____

Diet ☐ Great ☐ Good ☐ Fair ☐ Poor Comments _____
Are you vegetarian or vegan? ☐ Yes ☐ No For how long?_____

Food / Drink:

Foods You Crave_____When?_____

Daily Water Intake _____ Daily Soda Intake ____Caffeine? ☐ Yes ☐ No

Daily Coffee Intake _____ Caffeine? ☐ Yes ☐ No Daily Tea Intake _____Caffeine? ☐ Yes ☐ No

Do you drink alcohol? How Much?_____ How Often? _____ What kinds? _____
Past Use? ☐ Yes ☐ No Date Stopped _____

Do you use tobacco? ☐ Yes ☐ No Past Use? ☐ Yes ☐ No Date Stopped _____

Do you use recreational drugs? ☐ Yes ☐ No Past Use? ☐ Yes ☐ No Date Stopped _____

How do you feel about the following areas of your life in the past month.

Energy ☐ Great ☐ Good ☐ Fair ☐ Poor Comments_____
On a scale of 1 to 10? (10 is high energy)_____

Sleep ☐ Great ☐ Good ☐ Fair ☐ Poor Comments_____
Hours per night? _____ Do you wake feeling rested? ☐ Yes ☐ No

Sex Life ☐ Great ☐ Good ☐ Fair ☐ Poor Comments_____

School ☐ Great ☐ Good ☐ Fair ☐ Poor Comments_____

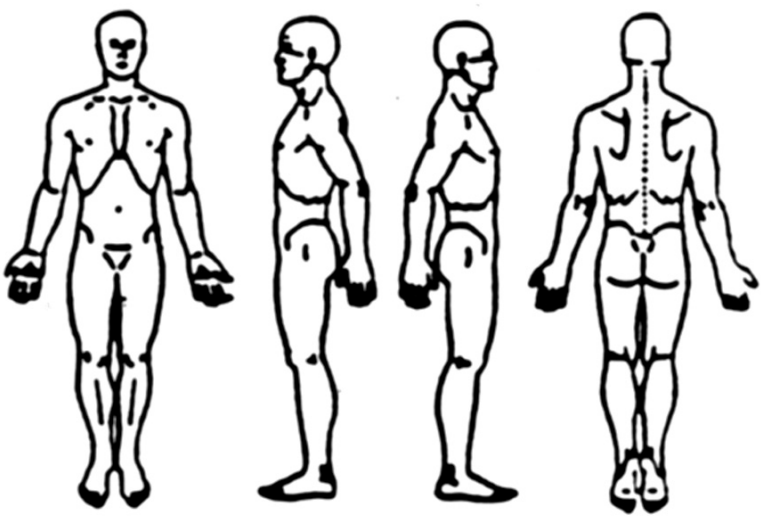
Exercise ☐ Great ☐ Good ☐ Fair ☐ Poor Comments_____
How often? _____ What kind? _____

How would you rate your stress level on a scale of 1 to 10? (10 is high stress) _____

How well do you feel you handle your stress? ☐ Great ☐ Good ☐ Fair ☐ Poor

Pain

Please answer the following questions if you have pain.



Indicate on the diagram your areas of pain

How long have you had this pain? _____

_____

Describe the onset of your pain?

_____

_____

_____

_____

_____

_____

_____

_____

_____

On a scale of 1-10 (10 being worst) how strong is your pain?_____

What does your pain feel like? (check all that apply)

☐ Dull ☐ Sharp ☐ Stabbing ☐ Sore ☐ Achy ☐ Cramping ☐ Burning ☐ Constant
☐ Comes and Goes ☐ Fixed ☐ Moves About

Does the pain radiate? ☐ No ☐ Yes Where? _____

What helps the pain? ☐ Ice ☐ Heat ☐ Rest ☐ Movement ☐ Pressure ☐ Moisture
☐ Massage ☐ Nothing ☐ Other _____

What aggravates the pain? ☐ Ice ☐ Heat ☐ Rest ☐ Movement ☐ Pressure ☐ Moisture
☐ Massage ☐ Nothing ☐ Other _____

Does anything relieve this pain? (i.e.; medications, over the counter drugs, liniments)

_____

Other treatments you have had for this pain? _____

_____

Anything you wish to add? _____

_____

_____

The above information is true to the best of my knowledge.

X Patient's Signature_____ Date _____