Health History Form

Please complete this questionnaire as thoroughly as possible. Successful healthcare and preventive medicine are only possible when the practitioner has a complete understanding of the patient's physical, mental, and emotional states. Print all information and indicate any areas in question. All your answers are completely confidential. Thank you.

Name: _____ Date: _____/_____/_____

Address: _____ City: _____ State: _____ Zip: _____

E-mail: _____ May we contact you via email? _____

Cell: _____ Home : _____ Work : _____

May we contact you by phone and leave a message if necessary? _____ At which number? _____

Date of Birth: ____/____/____ Age: _____ Gender: ____ Marital Status: _____ Height: ____ Weight: _____

Emergency Contact: _____
Name Relationship Phone

Occupation: _____ Hours of Work/Week: _____

Do you enjoy your work? _____ Why or why not? _____

Have you received acupuncture before? _____ If so, with whom? _____

Who can we thank for referring you? _____

Please identify the health concerns for which you are seeking treatment in order of importance below:

Condition	Past Treatment	Date Began
a._____	_____	_____

How does this condition affect you?_____

b._____	_____	_____

How does this condition affect you?_____

c._____	_____	_____

How does this condition affect you?_____

Please list any foods, drugs, or medications you are hypersensitive or allergic to, including your reaction:

_____

_____

_____

Please list all medications (prescribed or over-the-counter), vitamins, or supplements you are currently taking:

Medication	Dosage	Condition	How long?	Prescribed by?

Do you have any reason to believe you are pregnant? _____ If so, how far along are you? _____

Do you have any infectious diseases? _____ If yes, please identify: _____

Have you been diagnosed with a skin disease caused by staph? _____ Do you have MRSA? _____

If yes, please explain in more detail when it occurred and the treatment: _____

Please list any hospitalizations and surgeries:

Reason:	When:	Reason:	When:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Family History Please check those applicable and indicate year of diagnosis

	You	Father	Mother	Sisters	Brothers
Allergies	_____	_____	_____	_____	_____
Arthritis	_____	_____	_____	_____	_____
Asthma	_____	_____	_____	_____	_____
Cancer	_____	_____	_____	_____	_____
Diabetes	_____	_____	_____	_____	_____
Heart Disease	_____	_____	_____	_____	_____
Hepatitis	_____	_____	_____	_____	_____
High Blood Pressure	_____	_____	_____	_____	_____
Kidney Disease	_____	_____	_____	_____	_____
Mental Illness	_____	_____	_____	_____	_____
Seizures/Epilepsy	_____	_____	_____	_____	_____
Stroke	_____	_____	_____	_____	_____
Tuberculosis	_____	_____	_____	_____	_____

Childhood Illnesses:

___ Chicken Pox ___ Diphtheria ___ German Measles ___ Measles ___ Mumps ___ Rheumatic Fever

___Scarlet Fever Other:_____ Did you receive childhood immunizations? _____

Sexually Transmitted Infections:

___ Chlamydia ___ Gonorrhea ___Herpes ___HIV ___HPV ___Syphilis Other: _____

Please indicate which of the following symptoms you experience. Click the right column for the symptoms you experience occasionally and click the left column for the ones you experience frequently.

__ __Belching/burping
__ __Bloating
__ __Blood in stools
__ __Craving sweets
__ __Diarrhea/loose stools
__ __Easy bruising or bleeding
__ __Edema
__ __Excessive appetite
__ __Feel full quickly
__ __Feeling of food retained in stomach
__ __Foggy brain
__ __Heartburn/acid reflux
__ __Heaviness in limbs
__ __Lack of appetite
__ __Mucus in stools
__ __Nausea
__ __Obsessive or overthinking
__ __Tarry stools
__ __Tendency to gain weight
__ __Tired after eating
__ __Vomiting

__ __Angina pains
__ __Easily startled
__ __Heart palpitations
__ __Insomnia/difficulty sleeping
__ __Lack of joy in life
__ __Laughing for no apparent reason
__ __Mentally restless
__ __Nightmares/vivid dreams
__ __Sensation of heat in the chest

__ __Acne
__ __Allergies
__ __Asthma
__ __Bronchitis
__ __Colitis/diverticulitis
__ __Cough
__ __Coughing up phlegm
__ __Dry mouth, nose, throat
__ __Frequent colds/flu
__ __Grief/sadness
__ __Hemorrhoids
__ __Hives
__ __IBS/Crohn's Disease
__ __Nasal discharge
__ __Post nasal drip
__ __Red, itchy, painful throat
__ __Shortness of breath
__ __Skin rashes
__ __Sneezing
__ __Snoring

__ __Blurred vision/floaters
__ __Clench teeth at night
__ __Difficulty digestion oily foods
__ __Difficulty making decisions
__ __Dizziness/lightheadedness
__ __Easily angered/irritable
__ __Gallstones
__ __Jaundice
__ __Light colored stools
__ __Neck/back/shoulder tension/pain
__ __Spasms or muscle twitches

__ __Craving salty food
__ __Dry hair/skin
__ __Ear ringing
__ __Excessive sex drive
__ __Feels cold easily
__ __Feels fearful
__ __Feels lump in throat
__ __Hair loss
__ __Hearing impairment
__ __Hot flashes
__ __Kidney stones
__ __Knee pain
__ __Low back pain
__ __Low sex drive
__ __Night sweats
__ __Nighttime urination
__ __Poor memory, forgetful
__ __Soft/brittle/nails
__ __Urinary problems

Genito-urinary (Men)

Date of last prostate checkup: _____ PSA result: _____

Frequency of urination: Daytime _____ Nighttime _____ Urine: Clear ____ Cloudy ____Odor _____

__ Blood in urine
__ Burning on urination
__ Copious urine flow
__ Decreased libido
__ Delayed stream
__ Dribbling after urination
__ Groin pain
__ Impotence
__ Incontinence
__ Increased libido
__ Kidney stones
__ Nocturnal emission
__ Pain in testicles
__ Pain on urination
__ Premature ejaculation
__ Rectal dysfunction
__ Retention of urine
__ Scanty urine flow
__ Urgent urination
__ Urinary tract infection

Gynecological/Reproductive (Women)

Age of first menses: _____ Age of menopause: _____ Number of days between periods: _____

Number of days of flow: _____ Color of flow: _____ Clots? Color/size: _____

Average number of pads/tampons you use per day: 1st____ 2nd____ 3rd____ 4th____ 5th____ 6th____ 7th____

Number of pregnancies: ____ Live births: ____ Abortions: ____ Miscarriages: _____

Have you been diagnosed with any of the following:

☐ Fibroids ☐ Endometriosis ☐ Ovarian Cysts ☐ PCOS ☐ PID

Gynecological/Reproductive (Women) Continued

Please indicate if you experience the following in relation to your menses (before (B), during (D), after (A)):

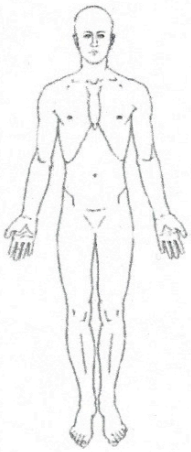
Pain: ☐ Aching ☐ Consistent ☐ Dull ☐ Sensation of bearing down
☐ Burning ☐ Cramping ☐ Intermittent ☐ Stabbing

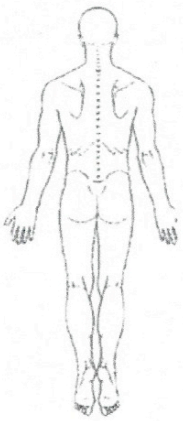
☐ Bloating	☐ Discharge	☐ Insomnia	☐ Poor appetite
☐ Constipation	☐ Headache	☐ Mood swings	☐ Ravenous appetite
☐ Decreased libido	☐ Hot flashes	☐ Nausea	☐ Swollen breasts
☐ Diarrhea	☐ Increased libido	☐ Night sweats	☐ Vaginal dryness

Musculoskeletal

☐ Back pain	☐ Hand/wrist pain	☐ Muscle pain	☐ Sciatica
☐ Bursitis	☐ Hip pain	☐ Muscle weakness	☐ Shoulder pain
☐ Carpal tunnel	☐ Knee pain	☐ Neck pain	☐ Sprains/strains
☐ Foot/ankle pain	☐ Limited range of motion	☐ Rotator cuff problems	☐ Tendonitis

Looking at the figures below, explain any injury, pain or discomfort you may be experiencing in the box below. Indicate the area of the body, the severity with a number from 1 (mild) to 10 (excruciating) and the quality; - aching, burning, numbness, pins & needles, or stabbing.





Lifestyle:

Number of meals eaten per day: _____ Number and types of snacks eaten per day: _____

What do you typically eat?

Breakfast: _____

Lunch: _____

Dinner: _____

What types and amounts of beverages do you drink each day? _____

_____

Do you drink at least 8 glasses of water per day? If not, how much?: _____

For the following substances please indicate type and average amount of current and/or past use (if applicable):

Caffeine: _____

Nicotine: _____

Alcohol: _____

Recreational Drugs: _____

Type(s) and amount(s) of exercise each week: _____

_____

Average hours of sleep per night: _____ Do you wake rested? Problems falling or staying asleep?

If yes, please describe: _____

Please choose your stress level _____

What are your primary sources of stress? _____

_____

Have you experienced any major traumas (i.e. abuse, major accidents, death of spouse/partner, etc.)? _____

If yes, please describe: _____

_____

_____

Is there anything else you would like us to know? _____

_____

_____

_____

_____

_____

_____

For office use only		
This form was reviewed on	by	Patient ID#: