**Ding Wellness Center**

www.dingwellnesscenter.com Tel: 614-330-8799 hdacupuncture@yahoo.com

## Health History Intake Form

Today's Date _____/_____/_____

Name _____ Gender ☐M ☐ F DOB_____/_____/_____

Address _____

City _____ State _____ Zip Code _____

**Your Contact Information**

Phone (614)-_____-_____ Email _____

**Emergency Contact**

Name _____ phone (614)-_____-_____

Your occupation _____ ☐ employed/ ☐ unemployed/ ☐ retired/ ☐ disabled

**Marital status** ☐Single/ ☐ Married/ ☐ Partner/ ☐ Divorced/ ☐ Widowed

Do you have a tendency of bleeding or bruising? ☐ yes ☐ no

Are you taking a blood thinner such as Aspirin? ☐ yes ☐ no

Do you have diabetes or lower immune function? ☐ yes ☐ no

Do you use a pacemaker? ☐ yes ☐ no

Do you currently have ☐HIV/☐Hepatitis/☐Tuberculosis/☐other infectious disease _____

**Main Problems You Would Like Us to Help With Acupuncture**

Main problem is _____

How long have you had this problem? _____

What makes it worse _____

What makes it better _____

When is it worse? ☐ Morning ☐ Afternoon ☐ Evening

If main complaint is pain, what does the pain feel like? _____,

how frequent does it occur? _____,

how long does an episode last? _____,

how severe it is (scale for 1 to 10, 10 is worst) _____/10,

Activities affected by this pain issue: _____,

Diagnosis you have been given by physician_____

Treatment you have tried _____

Medication list_____

Herb supplement_____

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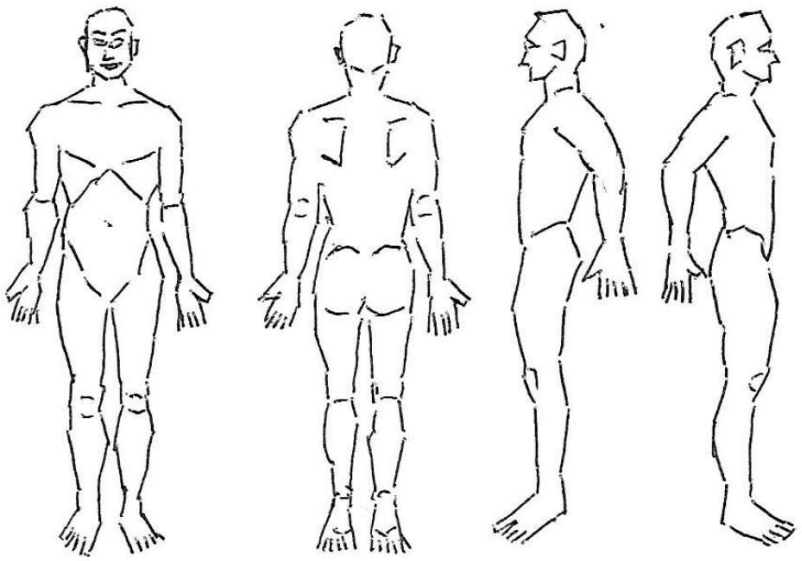
**Please cycle the area where you have pain**



**GENERAL HEALTH**

**Feel generally:** ☐cold/☐hot ☐energetic/☐tired ☐happy/☐sad/☐anxious/☐frustrated/ ☐irritated/☐scared ☐sweat at night/☐daytime

**Appetite:** ☐good/☐poor **Stress level**: ☐high/☐medium/☐low **Body weight**: ☐loss/☐gain

**Sleep**: ☐good and feel refreshed/☐ not feel refreshed, difficult in/☐falling asleep/☐staying asleep/☐dream disturbed/☐wake up frequently at night/☐wake up early sleep: ____h/night

**Stool**: ☐formed/☐loose/☐sticky/☐burning sensation/☐blood in it/☐constipated/
how often do you have bowel movement: _____

**Symptoms within the past three months**: (please check all it may apply)

☐Cough ☐coughing blood ☐wheezing ☐short of breath ☐difficulty breathing
☐chest pain ☐palpitations ☐ankle swelling ☐high/low blood pressure
☐gassy/bloated ☐heart burn ☐difficulty swallowing ☐ abdominal pain
☐nausea/☐vomiting ☐bowel habit change ☐frequent urination
☐urgency in urination ☐painful urination ☐difficult urination ☐blood in urine
☐unable to control or hold urine ☐urethral discharge ☐impotency ☐headache
☐loss of consciousness ☐dizziness ☐vertigo ☐speech problem ☐poor memory
☐vision problem ☐difficulty hearing ☐poor concentration ☐tremor ☐numbness

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☐bone or joint pain ☐joint swelling ☐muscles become thinner ☐muscle weakness

☐muscle cramp ☐dry skin/☐rashes/☐itching/☐acne/☐hives/☐hair loss/☐premature gray air

**PAST MEDICAL HISTORY**

Major illness and trauma_____

_____

Surgeries_____ Allergy_____

**FAMILY HISTORY**

Father:_____

Mother: _____

Siblings: _____

Grandparents: _____

**PERSONAL HISTORY and HABITS**

Alcohol: ☐none/☐yes: what kind of drinks_____, how many drinks/week_____

Caffeine: ☐none/☐yes: how many cups/day_____

Tobacco: ☐none/☐yes: how many boxes/week

What type of exercise do you do?_____ How often_____

**PREGNANCY & GYNECOLOGY**

Age of 1st menstruation_____ 1st day of last menstruation_____

Days of menstrual cycle_____ Days of menstruation_____

I am pregnant: ☐yes/☐no If pregnant, how many weeks right now_____

OB/GYN's name_____ contact information_____
address_____

**Describe your period**:

☐heavy/☐light ☐dark color/☐light red ☐clots ☐cramp before/☐during period

☐mood change before/☐during period ☐breast distension before/☐during period

☐spotting between periods ☐irregular periods ☐infertility

If you have cramps, what makes it better? ☐massage/☐warm up lower belly

Other symptoms: ☐vaginal discharge ☐vaginal sores ☐breast lumps

Number of births____ ☐vaginal deliver/☐c section Date of last Pap smear ___/___/___

Miscarriages/times____at which month_____abortions_____

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**You and your OB/GYN Plan for** assisted reproductive technology (ART) fertility treatments:

☐natural way ☐IUI ☐IVF ☐ ICSI

Stimulated ART cycle:

start date of follicle stimulation ___/___/___, medicine ☐Gonal F _____ other_____

Ovulation date ___/___/___ medicine ☐Ovitrelle_____ other_____

IUI date___/___/___

IVF date___/___/___