Healing Point Wellness Center

Confidential Health Information

Name: ____ Today's Date: ______ /______ /______

Address: ______________________________________ City: _______________ State: ________ Zip: __________

Phone Number: _____________________________________ Email: _____________________________________

What is the best way to contact you regarding appointments? ☐ Call ☐ Text ☐ Email ☐ No Contact

Date of Birth: _________ /_________ /_________ Age: _________ Height: _________ Weight: _________

What is your profession? ____ Do you enjoy it? ☐ Y ☐ N

Have you had acupuncture before? ☐ Y ☐ N - If so, where? ____

Emergency Contact: ____ Number: ___________________________

How did you hear about us? ____

Focus of Treatment

Please identify the health concerns/goals that brought you in today: _________________________________

____

____

How does this affect your daily life (relating to sleep, work, emotions, etc.)? ___________________________

____

What betters and/or worsens your condition(s)? ____

____

Are you seeking care from a physician for any of your health concerns? If so, please describe: __________

____

Have you sought any other treatment(s) for any of your health concerns? If so, please describe: _________

____

Please list all medications, vitamins, and/or supplements that you are currently taking:

Rx, Vitamin, Supplement	Dosage	Purpose	How long?

Have you recently had a course of antibiotics? ☐ Y ☐ N - If so, please identify: ____________________

Please list all known allergies or hypersensitivities (foods, medications, etc.): ____________________

____

Please indicate if you are taking any of the following:

☐ Blood thinners (Warfarin, Coumadin, etc.)
☐ Tranquilizers/Sedatives
☐ Pain Relievers (Ibuprofen, Tylenol, Aspirin, etc.)
☐ Cortisones or other Steroids
☐ Sleeping Aids
☐ Thyroid Medications
☐ Laxatives
☐ Antacids (Tums, etc.)

Please describe any previous accidents, hospitalizations, and/or surgeries: ____________________

____

____

Do you have a pacemaker? ☐ Y ☐ N - How would you rate your stress level 1-10 (10=worst)? ________

Do you have a special diet (i.e. vegan, gluten free, etc.)? ____________________

Please describe your weekly physical activity: ____________________

____

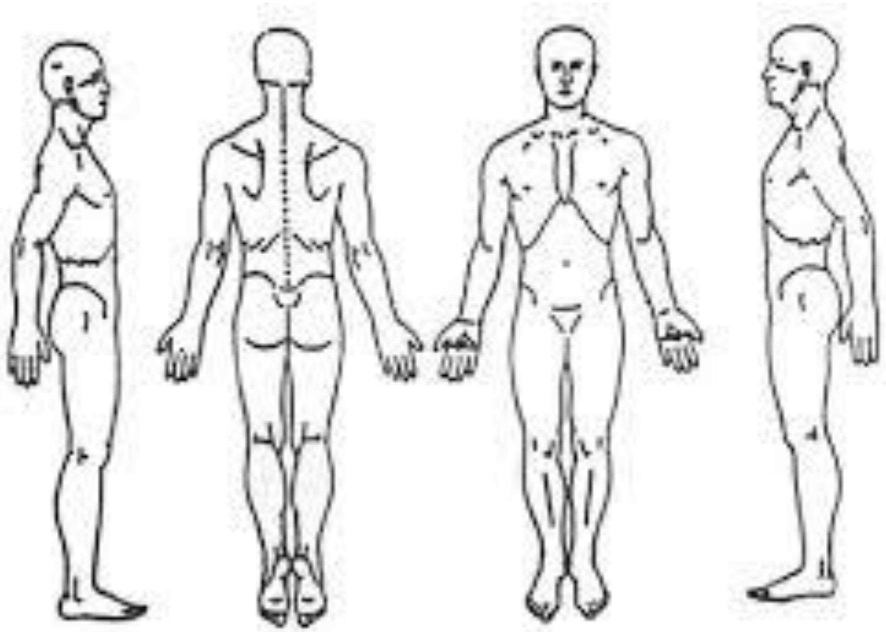
Please indicate if you or a blood relative (grandparent, parent, sibling) have had any of the following:

Illness	You	Relative	When?	Illness	You	Relative	When?
Cancer	☐	☐	________	Diabetes	☐	☐	________
Hepatitis	☐	☐	________	Heart Disease	☐	☐	________
High Blood Pressure	☐	☐	________	Seizures	☐	☐	________
High Cholesterol	☐	☐	________	Emotional Disorders	☐	☐	________
Rheumatic Fever	☐	☐	________	Tuberculosis	☐	☐	________
Asthma	☐	☐	________	Kidney Disease	☐	☐	________
Bleeding Disorder	☐	☐	________	Multiple Sclerosis	☐	☐	________

Sexually Transmitted Disease: ☐ Gonorrhea ☐ Syphilis ☐ HIV ☐ HPV ☐ Chlamydia ☐ Herpes

Pain Chart

Please mark any area(s) of injury, pain, or discomfort on the figure below. Indicate the severity with a number from 1 (minimal) to 10 (excruciating) and indicate the quality with the following symbols:
A – Achy ; B – Burning ; D – Dull ; H – Heavy ; N – Numbness ; R – Radiating ; S- Sharp ; T- Tingling



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Women's Health

Age at first period: __________ Date of last period: __________ Date of last OBGYN exam: __________

Are you currently on birth control? ☐ Y ☐ N - If so, for how long? ______________________________

Are you currently pregnant? ☐ Y ☐ N - If so, how far along are you? ___________________________

Are you currently trying to get pregnant? ☐ Y ☐ N - If so, for how long? ________________________

Please indicate whether you experience/ have been diagnosed with any of the following:

☐ Endometriosis	☐ Yeast Infections	☐ Genital Discharge	☐ Breast Cancer
☐ Ovarian Cysts	☐ UTIs	☐ PID	☐ Breast Lumps
☐ Uterine Fibroids	☐ Genital Pain/Itch	☐ Fibrocystic Breasts	☐ Nipple Discharge
☐ Genital Lesions	☐ Uterine Prolapse	☐ HPV	☐ Hysterectomy

# of days between periods: ________ # of days of flow: _______ Do you bleed between your periods? ☐ Y ☐ N

Average number of pads/tampons used per day: 1st ____ 2nd ____ 3rd ____ 4th ____ 5th ____ + days ____

What color is your menstrual blood ☐ Pale Red/Pink ☐ Red ☐ Bright Red ☐ Dark Red ☐ Purple ☐ Brown

Are your periods painful? ☐ Y ☐ N - Do you have clots? ☐ Y ☐ N - If so, what size? __________________

Do you experience any of the following related to your menses:

☐ Cravings	☐ Poor Appetite	☐ Mood Swings	☐ Hot Flashes	☐ Headaches	☐ Bloating
☐ Swollen Breasts	☐ Vaginal Dryness	☐ Constipation	☐ Diarrhea	☐ Night Sweats	☐ Nausea

Men's Health

Date of last prostate checkup: __________________ PSA result: _______________________________________

Frequency of urination: Daytime __________ Nighttime__________ Urine: ☐ Clear ☐ Cloudy ☐ Odorous

Please indicate whether you experience any of the following:

☐ Back Pain	☐ Discharge/Sores	☐ Testicular Lumps	☐ Kidney Stones
☐ Blood in Urine	☐ Dribbling after Urination	☐ Testicular Pain	☐ Urinary Retention
☐ Burning with Urination	☐ Groin Pain	☐ Nocturnal Emission	☐ Scanty Flow
☐ Copious Urine Flow	☐ Impotence	☐ Premature Ejaculation	☐ Urgent Urination
☐ Delayed Stream	☐ Incontinence	☐ Pain on Urination	☐ UTI

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Symptom Checker

Please indicate which of the following symptoms you experience. Use a checkmark (√) for the ones you *occasionally* experience, and a plus sign (+) for the ones you *frequently* experience.

___Belching/Burping
___Bloating
___Blood in stools
___Craving sweet
___Diarrhea/loose stool
___Easy bruising/bleeding
___Edema
___Excessive appetite
___Lack of appetite
___Feeling food retained in stomach
___Foggy brain
___Heartburn/Acid Reflux
___Heaviness in limbs
___Lack of appetite
___Mucus in stool
___Nausea
___Overthinking/Obsessive
___Tarry stools
___Tendency for weight gain
___Tired after eating
___Vomiting

___Chest pain
___Easily startled
___Palpitations
___Insomnia/difficulty sleeping
___ Nightmares/vivid dreams
___Laughing for no reason
___Mentally restless
___ Lack of joy in life
___Feeling heat in chest

___Acne
___Allergies
___Asthma
___Bronchitis
___Colitis/Diverticulitis
___Cough
___Dryness of mouth/nose/throat
___Frequent colds/flu
___Cough with phlegm
___Hemorrhoids
___Sneezing/nasal discharge
___IBS/Crohn's Disease
___Post nasal drip
___Red, itchy, painful throat
___Shortness of breath
___Skin rashes/hives
___Snoring
___Grief/sadness

___Blurred vision/floaters
___Clench teeth at night
___Difficulty digesting oily food
___Difficulty making decisions
___Dizziness/lightheadedness
___Easily angered/irritable
___Gallstones
___Neck/back/shoulder tension/pain
___Light colored stools
___Jaundice
___Spasms/muscle twitches
___High pitch ear ringing

___Craving salty food
___Dry hair/skin
___Low pitch ear ringing
___Excessive sex drive
___Low sex drive
___Feels fearful
___Hair loss
___Hearing impairment
___Hot flashes
___Kidney stones
___Knee pain
___Low back pain
___Night sweats
___Nighttime urination
___Poor memory/forgetful
___Feels cold easily
___Urinary problems
___Fatigue