

Health History Form

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Name (last, first) _____ Date _____

Address _____

City / State / Zip _____

Home phone _____ Work Phone _____

Cell Phone _____ Email _____

Occupation _____ Birth Date _____ Age _____

Emergency contact (*name & phone #*) _____

Referred by _____

Insurance (*type, ID #, phone number on card*) _____

___ Single ___ Married ___ Divorced ___ Significant Other ___ Widowed

___ Caregiver for dependent children (*how many*)? _____ for elderly person(s)? _____

Have you ever had acupuncture? _____ If yes, when? _____ for what condition?

_____ by whom? _____

Are you currently under the care of a physician? _____ If so, who, and for what condition(s)?

Have you seen any other medical care provider for this condition? If so please explain diagnosis: _____

Main reason(s) for seeking acupuncture today _____

How long have you experienced symptoms? _____

Your condition is improved by _____

Your condition is aggravated by _____

List all current medications, prescribed or over the counter, vitamins, herbs, and other supplements

Significant illnesses (please check all that apply)

- | | | |
|-------------------|------------------------|---------------------|
| ___ Cancer | ___ HIV/AIDS | ___ Pneumonia |
| ___ Tuberculosis | | |
| ___ Diabetes | ___ Multiple Sclerosis | ___ Thyroid |
| ___ Hepatitis | ___ Stomach Ulcers | ___ Obesity |
| ___ Heart Disease | ___ Shingles | ___ Chronic Fatigue |
| ___ Stroke | ___ Rheumatic Fever | ___ Seizures |
| | | ___ Asthma |
| | | ___ Depression |
| | | ___ STDs |
| | | ___ Emphysema |

Other _____

Please list any surgeries you've had, including dates:

Please list any allergies:

Please list any major emotional or physical traumas you've experienced

Lifestyle (please check all that apply, and note frequency of use)

Tobacco (cigs per day _____)
 Alcohol (drinks per day _____)
 Recreational drugs (type/amt _____)
 Caffeine (beverages per day _____)

Do you exercise? Yes No Please list types of activity and frequency:

Nutrition

Please check if any of these apply to you:

Vegetarian Vegan Raw foods diet Low fat diet
 High protein/low carb (Atkins) Other _____

Do you eat the following foods?

red meat _____ X per week fish _____ X per week
 artificial sweeteners _____ X per week coffee _____ X per week
 fast food _____ X per week white flour breads, pretzels, etc.
 salads cooked vegetables
 eggs

Gastro-Intestinal

Extreme appetite No appetite Nausea Bulimia
 Anorexia Cravings Dieting Tired after eating
 Bloating Gas Heartburn/GERD Gurgling
 Ulcers Extreme thirst Constipation Celiac
 Diarrhea Loose stools Hemorrhoids Gallbladder disease
 Mucus in stool Bloody stools Anal fissures Diverticulitis
 IBS Ulcerative colitis Crohn's Disease Gout
 Incomplete evacuation Laxative use Polyps Gallstones
 Rectal prolapse Fatigue between meals/low blood sugar Other _____

Sleep

Fall asleep easily Lie in bed with eyes open Wake at specific times
 Wake repeatedly Wake frequently to urinate Nightmares
 Dream-disturbed sleep Need drugs or supplements to fall asleep

Skin, Hair

Dry skin Rashes / hives Eczema Psoriasis
 Pimple/acne Fungal infections Brittle nails Ridged nails

<input type="checkbox"/> Hair loss	<input type="checkbox"/> Dandruff	<input type="checkbox"/> Other _____	
Head, Eyes, Ears, Nose and Throat			
<input type="checkbox"/> Dry eyes	<input type="checkbox"/> Floaters/spots	<input type="checkbox"/> Blurred vision	<input type="checkbox"/> Poor vision
<input type="checkbox"/> Eye strain	<input type="checkbox"/> Night blindness	<input type="checkbox"/> Cataracts	<input type="checkbox"/> Glaucoma
<input type="checkbox"/> Itchy eyes	<input type="checkbox"/> Macular degeneration	<input type="checkbox"/> Excess tearing	<input type="checkbox"/> Dry mouth
<input type="checkbox"/> TMJ	<input type="checkbox"/> Excess saliva	<input type="checkbox"/> Canker sores	<input type="checkbox"/> Cold sores
<input type="checkbox"/> Sinus problems	<input type="checkbox"/> Post-nasal drip	<input type="checkbox"/> Frequent sore throats	<input type="checkbox"/> Headaches
<input type="checkbox"/> Swollen glands	<input type="checkbox"/> Difficulty swallowing	<input type="checkbox"/> Earaches	<input type="checkbox"/> Nosebleeds
<input type="checkbox"/> Tinnitus/ringing	<input type="checkbox"/> Hearing impairment	<input type="checkbox"/> Other _____	

Cardiovascular/Respiratory

<input type="checkbox"/> Palpitations	<input type="checkbox"/> Chest pain	<input type="checkbox"/> Difficulty breathing	<input type="checkbox"/> High cholesterol
<input type="checkbox"/> Varicose veins	<input type="checkbox"/> Hypertension	<input type="checkbox"/> Swollen ankles	<input type="checkbox"/> Shortness of breath
<input type="checkbox"/> Wheezing	<input type="checkbox"/> Chest tightness	<input type="checkbox"/> Dry cough	<input type="checkbox"/> Productive cough
<input type="checkbox"/> Cold hands/feet	<input type="checkbox"/> Blood clots	<input type="checkbox"/> Heart valve abnormality	
<input type="checkbox"/> Other _____			

Musculoskeletal

<input type="checkbox"/> Low back pain	<input type="checkbox"/> Joint pain	<input type="checkbox"/> Tendonitis	<input type="checkbox"/> Swelling
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Disc degeneration	<input type="checkbox"/> Osteoporosis	<input type="checkbox"/> Numbness
<input type="checkbox"/> Neck pain	<input type="checkbox"/> Shoulder pain	<input type="checkbox"/> Hip pain	<input type="checkbox"/> Knee pain
<input type="checkbox"/> Mid back pain	<input type="checkbox"/> Upper back pain	<input type="checkbox"/> Elbow pain	<input type="checkbox"/> Jaw pain
<input type="checkbox"/> Carpal tunnel	<input type="checkbox"/> Limited range of motion	<input type="checkbox"/> Other _____	

Neuropsychological

<input type="checkbox"/> Anxiety	<input type="checkbox"/> Irritability	<input type="checkbox"/> Insomnia	<input type="checkbox"/> Depression
<input type="checkbox"/> Easily stressed	<input type="checkbox"/> Poor memory	<input type="checkbox"/> Tics	<input type="checkbox"/> Tremors
<input type="checkbox"/> Job stress	<input type="checkbox"/> Recent divorce	<input type="checkbox"/> Financial setback	<input type="checkbox"/> Mood swings
<input type="checkbox"/> Difficulty concentrating	<input type="checkbox"/> Seasonal mood disorder	<input type="checkbox"/> Death of someone close	
<input type="checkbox"/> Currently in therapy	<input type="checkbox"/> Formerly in therapy	<input type="checkbox"/> Other _____	

Emotional stress scale

1 2 3 4 5 6 7 8 9 10
 no stress—moderate—extremely stressed

Rate your stress level regarding the following areas (1 is low, 10 is high)

<input type="checkbox"/> Work	<input type="checkbox"/> Health	<input type="checkbox"/> Love	<input type="checkbox"/> Money
<input type="checkbox"/> Family	<input type="checkbox"/> Friends	<input type="checkbox"/> Future	<input type="checkbox"/> Living conditions
<input type="checkbox"/> Isolation	<input type="checkbox"/> Responsibilities	<input type="checkbox"/> Past	<input type="checkbox"/> Weight

Genito-urinary

<input type="checkbox"/> Frequent urination	<input type="checkbox"/> Dribbling	<input type="checkbox"/> Burning	<input type="checkbox"/> Blood in urine
<input type="checkbox"/> Incomplete urination	<input type="checkbox"/> Kidney stones	<input type="checkbox"/> Bedwetting	<input type="checkbox"/> Bladder prolapse
<input type="checkbox"/> Genital pain	<input type="checkbox"/> Loss of urine when laughing, sneezing, or coughing		
<input type="checkbox"/> Decreased libido/sexual desire	<input type="checkbox"/> Other _____		

Men only:

Enlarged prostate Prostate cancer Testicular cancer Herpes
 Impotency Erectile dysfunction Testicular pain/swelling
 STD _____

Women only:

Date of last OB/GYN exam _____ Hysterectomy? partial full

Painful intercourse Live births Miscarriage Abortion(s)
 Infertility Birth control pills Breast cancer Herpes
 Fibroids Endometriosis Candida/yeast PMS
 Vaginal discharge Vaginal odor Vaginal sores Dry vagina
 HPV positive Fibrocystic breast Ovarian cyst Prolapse
 Hormone replacement Hot flashes Nightsweats Mood swings
 STD _____

Age menses began _____ Age menses ended (if applicable) _____

Period lasts _____ days Usual number of days in cycle _____
 Bleeding/spotting outside of normal menstrual cycle
 Irregular cycle
 No period/skipped cycles

Menstrual flow:

Heavy Light Watery/thin Fresh red blood
 Brownish Purplish/dark Clots Flooding & trickling

Headaches before menstrual cycle during cycle after cycle

Associated with cycle:

Pain at ovulation Pain at start of period Pain during period
 Low back pain Irritability Weepiness/depression
 Diarrhea Constipation Acne
 Breast tenderness Nausea Insomnia
 Cramps

Please note any other concerns that may have been missed on this form:
