

Acupuncture Health History

This form will gather your in-depth history according to Traditional Chinese Medicine (TCM). This will help determine the level, location, and severity of support necessary for complete wellness. Our services provide support emotionally, physically, and spiritually to you as a whole individual. Thank you for taking these steps to whole wellness.

"Be not afraid of growing slowly, be afraid only of standing still." - Chinese Proverb

Date ___/___/___ Name _____
Home Phone _____ Cell Phone _____ Work Phone _____
Address _____
City State Zip

Social Security #: _____ - _____ - _____ Date of Birth ___/___/___
Sex: Male Female Marital Status: Married Single Divorced
 Separated Widowed

Occupation: _____
Employer: _____
Employer Address: _____
Employer Phone: _____
Spouse/Partner Name: _____ Spouse/Partner Birth Date: ___/___/___
Spouse/Partner Phone: _____ Spouse/Partner Employer: _____

How did you hear about our clinic? _____
Have you ever acupuncture? _____
In the case of an emergency, notify whom: _____
Who is your family physician? _____

What are your beliefs about acupuncture? (Both positive or negative)

What are your main concerns, in order of importance?

How have these problems affected you?

Any health conditions diagnosed?

Any surgeries?

Any implantation devices within your body (ie. Metal, Pacemaker, Rods, Prosthetics)?

Any allergies(food, drug, chemical)?

Do you smoke, drink alcohol, or use caffeine products?

Please list all, if any, vitamins & supplements, medications, recreational drugs, or herbs that you may take:

Please describe your average daily diet: (Are you getting recommended amts. of fruits, vegetables, etc.?)

Would you like any information on nutrition? Yes No

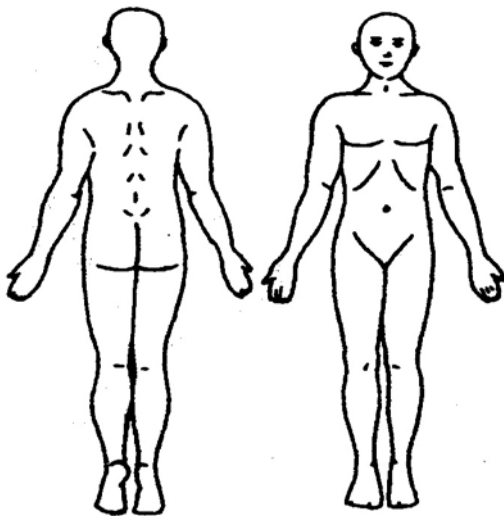
What type of exercise do you get, and how much time per day (cardiovascular, weights, yoga, etc.)?

Would you like any information on exercise? Yes No

What feelings of stress do you have, if any? _____

Would you like information on mind/body awareness or dealing with stressors (meditation, qi gong, tai qi, affirmations, etc.)? Yes N

Please mark the areas that bother you, on the diagram below:



Specify area and quality of pain (ie.elbow: numbness/dull/achy/sharp/shooting):

Check any that you have or had in the past:

- | | | |
|--|---|---|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Allergies |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Stroke | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> HIV/AIDS |
| <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Mononucleosis | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Genital Herpes |
| <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Thyroid Problems | <input type="checkbox"/> Blood disorder |
| <input type="checkbox"/> Obesity | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Gallstones |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Sexually Transmitted Disease | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Eating Disorders | <input type="checkbox"/> Hernia |
| <input type="checkbox"/> Drug/Alcohol Addictions | | |

General

- | | | |
|---|---|--|
| <input type="checkbox"/> Head or Chest Cold | <input type="checkbox"/> Flu | <input type="checkbox"/> Fevers |
| <input type="checkbox"/> Night Sweats | <input type="checkbox"/> Chills | <input type="checkbox"/> Low Energy |
| <input type="checkbox"/> Thirsty | <input type="checkbox"/> Lack of Thirst | <input type="checkbox"/> Edema |
| <input type="checkbox"/> Sore knees | <input type="checkbox"/> Body temperature | <input type="checkbox"/> Low Backache |
| <input type="checkbox"/> Weight Changes | __ Feel warm __ Feel Cold | <input type="checkbox"/> Short of Breath |

Sleep

- | | | |
|--|---|--|
| <input type="checkbox"/> Difficulty Falling Asleep | <input type="checkbox"/> Nightmares | <input type="checkbox"/> Shallow Sleep |
| <input type="checkbox"/> Wakes during sleep | <input type="checkbox"/> Active mind during evening | <input type="checkbox"/> Snoring |
| <input type="checkbox"/> Difficulty waking | <input type="checkbox"/> Wake with low energy | <input type="checkbox"/> Night Sweats |
| <input type="checkbox"/> A lot of dreaming | | |

Digestion

How many bowel movements do you pass in a day? _____

- | | |
|---|---|
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Diarrhea |
| <input type="checkbox"/> Dry and hard stool | <input type="checkbox"/> Watery feces |
| <input type="checkbox"/> Feel better after bowel movement | <input type="checkbox"/> Burning of anus when passing |
| <input type="checkbox"/> Bleeding of anus | <input type="checkbox"/> Pain in lower abdomen |
| <input type="checkbox"/> Abdominal cramping | <input type="checkbox"/> Cold sensation in abdomen |
| <input type="checkbox"/> Mucus in stool | <input type="checkbox"/> Undigested food in stool |
| <input type="checkbox"/> Blood in stool | <input type="checkbox"/> Hard to pass stool |

- | | | |
|--|---|--|
| <input type="checkbox"/> Bitter taste in mouth | <input type="checkbox"/> Rib pain or tenderness | <input type="checkbox"/> Stomach acidity |
| <input type="checkbox"/> Stomach ulcer | <input type="checkbox"/> Bad breath | <input type="checkbox"/> Gallstones |
| <input type="checkbox"/> Belching | <input type="checkbox"/> Flatulence (Gas) | <input type="checkbox"/> Low appetite |
| <input type="checkbox"/> Hungers easily | <input type="checkbox"/> Sour Regurgitation | <input type="checkbox"/> Hemorrhoids |
| <input type="checkbox"/> Teeth/ Gum Problems | <input type="checkbox"/> Bloating | <input type="checkbox"/> Hernia |

Eyes

- | | | |
|---|--|---|
| <input type="checkbox"/> Sensitive to light | <input type="checkbox"/> Watery Eyes | <input type="checkbox"/> Itchy Eyes |
| <input type="checkbox"/> Dry Eyes | <input type="checkbox"/> Floating spots over eye | <input type="checkbox"/> Blurred vision |

Head, Ears, Nose, Mouth, and Throat

- | | | |
|---|--|--|
| <input type="checkbox"/> Frequent colds | <input type="checkbox"/> Sinus Congestion | <input type="checkbox"/> Bleeding Gums |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Sores in mouth | <input type="checkbox"/> Swollen lymph nodes |
| <input type="checkbox"/> Lump in Throat | <input type="checkbox"/> Nose Bleeds | <input type="checkbox"/> Migraine Headache |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Sore Throat | <input type="checkbox"/> Dry Mouth |
| __ Front of Head | <input type="checkbox"/> Thirsty for liquids | <input type="checkbox"/> Ringing in Ears |
| __ Side of Head | __ Cold beverages | __ High Pitch |
| __ Back of Head | __ Warm beverages | __ Low Pitch |

Chest

- | | | |
|--|--|--|
| <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Irregular heartbeat | <input type="checkbox"/> Rapid Heartbeat |
| <input type="checkbox"/> Palpitations | <input type="checkbox"/> Chest feels heavy | <input type="checkbox"/> Cough |

Skin and Hair

- | | | |
|---|--|--------------------------------------|
| <input type="checkbox"/> Dry Skin | <input type="checkbox"/> Itching | <input type="checkbox"/> Boils |
| <input type="checkbox"/> Weak/Brittle Nails | <input type="checkbox"/> Moist Feet | <input type="checkbox"/> Moist Palms |
| <input type="checkbox"/> Hair loss | <input type="checkbox"/> Acne or Pimples | |

Urination

- | | | |
|---|---|--|
| <input type="checkbox"/> Cloudy urine | <input type="checkbox"/> Urgency to urinate | <input type="checkbox"/> Dribbling |
| <input type="checkbox"/> Blood in urine | <input type="checkbox"/> Frequent urination | <input type="checkbox"/> Strong smelling urine |
| <input type="checkbox"/> Large amt. of urine | <input type="checkbox"/> Dark urine | <input type="checkbox"/> Decreased flow of urine |
| <input type="checkbox"/> Pain or burning upon urination | | <input type="checkbox"/> Backache |
| <input type="checkbox"/> Trouble starting to urinate | | |

Psychological

- | | | |
|--|---|--|
| <input type="checkbox"/> Depression | <input type="checkbox"/> Manic Episodes | <input type="checkbox"/> Obsessiveness/Compulsive |
| <input type="checkbox"/> Angry | <input type="checkbox"/> Irritated | <input type="checkbox"/> Repress Emotions |
| <input type="checkbox"/> Mood Swings | <input type="checkbox"/> Sadness or Grief | <input type="checkbox"/> Frequent Crying |
| <input type="checkbox"/> Anxiety or Fear | <input type="checkbox"/> Indecisiveness | <input type="checkbox"/> Difficult verbal expression |
| <input type="checkbox"/> Poor Memory | | |
| __ Short Term Memory | | |
| __ Long Term Memory | | |

Sexual Health

- | | | |
|---|--|--|
| <input type="checkbox"/> Low Sex Drive | <input type="checkbox"/> High Sex Drive | <input type="checkbox"/> Prostate Problems |
| <input type="checkbox"/> Premature ejaculation | <input type="checkbox"/> Low sperm count | <input type="checkbox"/> Vaginal Dryness |
| <input type="checkbox"/> Inability to maintain erection | <input type="checkbox"/> Vaginal discharge | |
| | __sticky __thin __foul odor __no odor | |
| | __yellow __white __clear __itchiness | |

Men Only:

- | | | |
|--|---|---|
| <input type="checkbox"/> Swollen testes | <input type="checkbox"/> Testicular pain | <input type="checkbox"/> Impotence |
| <input type="checkbox"/> Premature ejaculation | <input type="checkbox"/> Low sex drive | <input type="checkbox"/> High sex drive |
| <input type="checkbox"/> Inability to achieve erection | <input type="checkbox"/> Cold or Numb sensation in external genitalia | |

Women Only:

What is your method of birth control? _____

Are You Pregnant? Yes No

Pregnancy and Menstrual History

___ Age of 1st menstruation

_____ Date of last menstruation

___ Days in Menstrual Flow

___ Days in Cycle (28-35days)

___ Age of Menopause:

___ Number of Miscarriages

___ Number of Children

___ Number of Abortions

Women Only Continued:

- | | |
|--|--|
| <input type="checkbox"/> Infertility | <input type="checkbox"/> Hysterectomy |
| <input type="checkbox"/> Ovarian Cysts | <input type="checkbox"/> Endometriosis |
| <input type="checkbox"/> Breast Cysts | <input type="checkbox"/> Breast Cancer |
| <input type="checkbox"/> Spotting between periods | <input type="checkbox"/> Cannot Maintain Pregnancy |
| <input type="checkbox"/> Pelvic Inflammatory Disease | <input type="checkbox"/> Irregular Cycle |
| <input type="checkbox"/> Breast Tenderness | <input type="checkbox"/> Cramping |
| <input type="checkbox"/> Low backache | <input type="checkbox"/> Painful periods |
| <input type="checkbox"/> PMS Diarrhea | <input type="checkbox"/> PMS constipation |
| <input type="checkbox"/> PMS irritability | <input type="checkbox"/> PMS emotionally sensitive |

Consistency of Blood:

- | | | |
|---|---------------------------------------|-------------------------------------|
| <input type="checkbox"/> Pale red blood | <input type="checkbox"/> Purple clots | <input type="checkbox"/> Red Clots |
| <input type="checkbox"/> Dark or brownish blood | <input type="checkbox"/> Heavy Flow | <input type="checkbox"/> Light Flow |
| <input type="checkbox"/> Fire Engine Red Blood | <input type="checkbox"/> Thick/Sticky | <input type="checkbox"/> Watery |

I consent to a professional and complete examination and to any recommendations of care involving acupuncture or any other form of therapy deemed appropriate for my personal care. All the information provided is to the best of my knowledge.

Signature _____ Date _____