Acupuncture Health History Form

|  |  |  |
| --- | --- | --- |
| Patient Information | | |
| Name |  | Date |
| Address | | |
| City | State | Zip |
| Home Phone |  | Cell Phone |
| Heiqht Weiqht | Sex: □ Male | □ Female Marital Status |
| Date of Birth | Aqe |  |
| Occupation | Employer | |

Have you had acupuncture before? □ No □ Yes, Name of Acupuncturist

**Major Complaint**

Primary reason for your visit today?

Has this condition been diagnosed by a physician, or other provider?

□ No □ Yes, Diagnoses

Are you being treated for this condition by anyone else? □ Yes □ No

If yes, what is the treatment?

Have these treatments helped? □ Yes □ Somewhat □ Not Much □ Not At All

How does this condition affect you?

How long have you had this condition?

**Personal Health History**

Your general health as a child was? □ Excellent □ Good □ Average □ Poor

Did you feel safe and nurtured as a child? □ Always □ Usually □ Sometimes □ Never

Check all the illnesses or conditions which **you** currently have or have had in the past:

* AIDS/HIV
* Alcoholism
* Allergies
* Antibiotic Use
* Asthma
* Bleed Easily
* Cancer
* Chicken Pox
* Diabetes
* Drug Abuse
* Eating Disorders
* Epilepsy
* Glaucoma
* Heart Disease
* Hepatitis
* High Blood Pressure
* High Fevers
* Hyperthyroid
* Hypothyroid
* Jaundice
* Kidney Disease
* Measles
* Meningitis
* Mental Illness
* Multiple Sclerosis
* Mumps
* Obesity
* Pneumonia
* Polio
* Other
* Rheumatic Fever
* Scarlet Fever
* Sexually Transmitted  
  Disease
* Stroke
* Tuberculosis
* Typhoid Fever
* Ulcers
* Vascular Disease

Are you taking Coumadin or Warfarin? □ Yes □ No

Do you have a pacemaker? □ Yes □ No Do you have seizures? □ Yes □ No

Do you currently have any infectious diseases? □ Yes □ No □ Possibly

If yes, please identify: □ HIV/AIDs □ Hepatitis B □ Hepatitis C □ Flu / Cold n Streptococcus

□ Mononucleosis □ Tuberculosis □ Other

Known or suspected allergies:

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**Personal Health Inventory**

Please put a check mark ( ✓ )by the symptoms that you have now.

Place a star ( \* ) next to the ones you have noticed within the last three months.

Qi, Blood, Yin, Yang

* anxiety
* catches colds easily  
  or frequently
* chest pain traveling to shoulder
* cold feet
* cold hands
* difficult to concentrate
* dizziness
* dream disturbed sleep
* dry skin
* fatigue
* feverish in the afternoon  
  or flushes
* general weakness
* heat sensations in hands,  
  feet, chest
* insomnia
* mental confusion
* night sweats
* palpitations
* restlessness
* sores on tip of tongue
* speech problems
* sweats easily
* thirst, at night
* you feel worse after exercise
* you see floating black spots

LU

* allergies
* chills alternating with fever
* cough
* difficulty breathing
* dry mouth, throat, nose
* feeling achy
* headaches
* nasal discharge
* nose bleeds
* shortness of breath
* sinus congestion
* sneezing
* sore throat
* stiff neck/ shoulders

SP

* abdominal bloating and / or  
  gas after eating
* belching
* chest congestion
* constipation
* diarrhea
* eating disorders
* fatigue after eating
* gas
* general feeling of heaviness  
  in your body
* hemorrhoids
* loose stools
* low appetite
* mental heaviness,  
  sluggishness or fogginess
* nausea
* prolapsed organs  
  (previously diagnosed)
* swollen feet
* swollen hands
* you bruise easily

ST

* bad breath
* belching
* bleeding, swollen or  
  painful gums
* burning sensation after eating
* constipation
* heartburn
* large appetite
* mouth sores  
  (canker or cold sores)
* stomach pain
* vomiting

**HT/PC**

* chest pain
* edema
* high blood pressure
* insomnia
* low blood pressure
* palpitations
* stroke
* varicose veins

**LR/GB**

* bitter taste in mouth
* blood shot eyes
* blurred vision
* chest pain
* convulsions
* diarrhea alternating  
  with constipation
* difficulty swallowing
* dry eyes
* feeling of a lump in  
  your throat
* headache at the top of  
  your head
* hot flashes
* muscle spasms, twitching,  
  cramping
* numbness of hands and feet
* pain in rib cage
* red, sore or irritated eyes
* seizures
* skin rashes
* tight feeling in chest
* TMJ or locked jaw
* you anger easily
* you feel better after exercise

**KI/BL**

* frequent urination
* hair loss
* joint pain
* lack of bladder control
* loose teeth
* low back pain
* memory problems
* night blindness or low vision
* ringing in your ears
* sore, cold or weak knees
* you get up more than one  
  time at night to urinate

Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Family History**

How do you feel about the following areas of your life in the past month?

Significant Other □ Great □ Good □ Fair □ Poor □ N/A Comments

Family □ Great □ Good □ Fair □ Poor □ N/A Comments

Self □ Great □ Good □ Fair □ Poor Comments

Check illnesses which have occurred in any of your **blood relatives**:

* Alcoholism □ Cancer □ Pleart Disease □ Mental Illness
* Allergies □ Diabetes □ High Blood Pressure □ Obesity
* Bleed Easily □ Epilepsy □ Kidney Disease □ Stroke
* Other

**Women Only**

Are you pregnant? □ Yes, How many months? □ No □ Trying □ Maybe

Method of birth control?

Age of First Menses Date of Last Menses Age of Menopause

Typical Length of Menses (Days You Bleed)

Typical Length of Cycle (From the 1st Day of One Cycle to 1st Day of the Next)

|  |  |  |
| --- | --- | --- |
| Number of: Pregnancies | Births Abortions | Miscarriages |
| Hysterectomy □ Yes □ Partial | □ Complete Date | □ No |
| Check all that apply to you: | | |
| □ Scanty Flow | □ Painful Periods | □ Low Libido |
| □ Heavy Flow | □ Breast Tenderness | □ Excessive Libido |
| □ Clotting | □ Breast Lumps | □ Painful Intercourse |
| □ Vaginal Discharge | □ Nipple Discharge | □ Infertility |
| □ Abnormal Pap Smear | □ Fibrocystic Breasts | □ Fibroids |
| □ Menopausal Symptoms | □ Bleeding Between Cycles | □ Endometriosis |
| □ Premenstrual Problems | □ Irregular Cycles | □ Ovarian Cysts |

□ Other

**Men Only**

Check all that apply to you:

* Low Libido □ Seminal Emissions
* Excessive Libido □ Premature Ejaculation
* Impotence □ Painful Intercourse
* Vasectomy, Date

Other

* Prostate Problems
* Testicular Pain
* Testicular Redness
* Testicular Swelling

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Medications Please list medications, herbal supplements and vitamins you are currently taking:

How would you rate the following areas of your health in the past month.

Digestion □ Great □ Good □ Fair □ Poor Comments

Stools □ Great □ Good n Fair □ Poor Comments

How many times per day? Do they feel complete? □ Yes □ No

Stool consistency? □ Loose □ Formed □ Hard to Pass □ Other

What is the color of your stools?

Is there blood in your stools? □ Yes □ No How Often?

Urination □ Great □ Good □ Fair □ Poor Comments

How many times per day? What color is your urine?

After you've gone to sleep do you get up to urinate? □ Yes □ No How Often?

Is your urination painful? □ Yes □ No

Appetite □ Great □ Good □ Fair □ Poor Comments

Diet □ Great □ Good □ Fair Q Poor Comments

Are you vegetarian or vegan? □ Yes □ No For how long?

Food / Drink:

Foods You Crave When?

Daily Water Intake Daily Soda Intake Caffeine? □ Yes □ No

Daily Coffee Intake Caffeine? □ Yes □ No Daily Tea Intake Caffeine? □ Yes □ No

Do you drink alcohol? How Much? How Often? What kinds?

Past Use? □ Yes □ No Date Stopped

Do you use tobacco? □ Yes □ No Past Use? □ Yes □ No Date Stopped

Do you use recreational drugs? □ Yes □ No Past Use? □ Yes □ No Date Stopped

How do you feel about the following areas of your life in the past month.

Energy □ Great □ Good □ Fair □ Poor Comments

On a scale of 1 to 10? (10 is high energy)

□ Great □ Good □ Fair □ Poor Comments

Sleep

Sex Life

School

Exercise

Hours per night? \_

* Great □ Good
* Great □ Good
* Great □ Good  
  How often?
* Fair □ Poor
* Fair □ Poor
* Fair □ Poor

Do you wake feeling rested? □ Yes □ No

Comments

Comments

Comments

What kind?

How would you rate your stress level on a scale of 1 to 10? (10 is high stress)

How well do you feel you handle your stress? □ Great □ Good □ Fair n Poor

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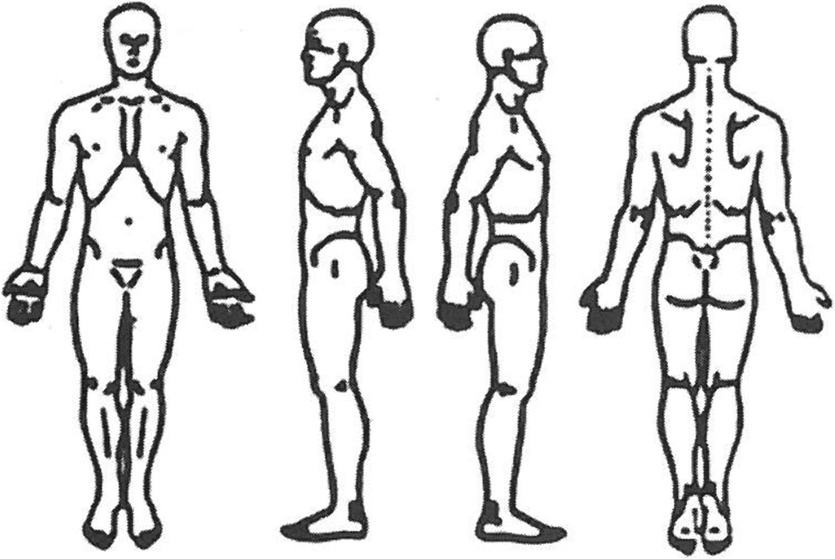
**Drug / Supplement / Vitamin Reason For Taking For How Long Dosage Frequency**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
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|  |  |  |  |  |

**Lifestyle**

**Pain**

Please answer the following questions if you have pain.



Indicate on the diagram your areas of pain

How long have you had this pain?

Describe the onset of your pain? \_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

On a scale of 1-10 (10 being worst) how  
strong is your pain?

What does your pain feel like? (check all that apply)

* Dull □ Sharp □ Stabbing □ Sore □ Achy □ Cramping □ Burning □ Constant
* Comes and Goes □ Fixed n Moves About

Does the pain radiate? □ No □ Yes Where?

What helps the pain? □ Ice □ Heat □ Rest □ Movement □ Pressure □ Moisture

* Massage □ Nothing □ Other

What aggravates the pain? □ Ice □ Heat □ Rest □ Movement □ Pressure □ Moisture

* Massage □ Nothing □ Other

Does anything relieve this pain? (i.e.; medications, over the counter drugs, liniments)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other treatments you have had for this pain?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Anything you wish to add

The above information is true to the best of my knowledge.

X Patient's Signature Date

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