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Health History Form

Patient Information

Today's Date	Have you ever received acupuncture before?
Last Name: Middle: First:	Preferred Name:
Street Address:	Date of Birth:

City:	State:	Zip:
Primary Contact #:	Alternate Contact #:	Email:

☐ Single ☐ Married ☐ Divorced ☐ Domestic Partnership ☐ Other

Emergency Contact

Name:	Relationship:
Phone Number:	Cell/Work Number:

Physician Information

Name:	Phone:
Location:	

Occupation

Current Occupation:

Hobbies or Passions:

Primary Health Questions

Please list your primary reasons for seeking acupuncture:

How long have you had this/these issues?

Primary Health Questions Cont'd

Does anything make the condition better? If Yes, what?

Does anything make the condition worse? If Yes, what?

Have you been treated for any of these conditions before? If Yes, please explain what type of treatment you received.

Are you being treated for any other medical conditions?

How did you hear about us?

Medications

Do you have allergies to medications? If yes, please list them:

List Pharmaceuticals, both prescription and over-the-counter, that you are currently taking:

List all herbal prescriptions and supplements you are taking:

Diet

Do you have any food allergies or sensitivities?

Please describe your current usage of the following substances:

Caffeine	cups per day	________________
Cigarettes	per day	________________
Alcohol	per day/week	________________
Recreational Drugs	per day/week	________________

Family Health History (even if adopted)

	Father	Mother	Siblings	Grandparents
Age (if living)	______	______	______	______
Health	______	______	______	______
Cancer	______	______	______	______
Diabetes	______	______	______	______
Heart Disease	______	______	______	______
HBP	______	______	______	______
Stroke	______	______	______	______
Mental Illness	______	______	______	______
Asthma	______	______	______	______
Kidney Disease	______	______	______	______

Signs & Symptoms

Please check any of the following boxes that correspond to health issues you have experienced in the past or are presently experiencing.

General

past	current	
☐	☐	Insomnia
☐	☐	Dreams/nightmares
☐	☐	Cold hands/feet
☐	☐	Chills
☐	☐	Fever
☐	☐	Night sweats
☐	☐	Decreased ability to taste
☐	☐	Sweet taste in mouth
☐	☐	Metallic taste in mouth
☐	☐	Crave spicy foods
☐	☐	Crave sweets
☐	☐	Crave salty foods
☐	☐	Crave sour foods
☐	☐	Crave bitter foods
☐	☐	Irritability
☐	☐	Depression
☐	☐	Anxiety
☐	☐	Mood swings
☐	☐	Fatigue
☐	☐	Often worried
☐	☐	Indecisiveness
☐	☐	Poor memory

Head & Neck

past	current	
☐	☐	Headaches
☐	☐	Migraines
☐	☐	Stiff neck
☐	☐	Dizziness
☐	☐	Fainting
☐	☐	Swollen glands
☐	☐	Whiplash

Eyes

past	current	
☐	☐	Corrective lenses
☐	☐	Blurred vision
☐	☐	Poor night vision
☐	☐	Spots or floaters
☐	☐	Eye inflammation
☐	☐	Dryness
☐	☐	Tearing
☐	☐	Glaucoma
☐	☐	Cataracts

Ears

past	current	
☐	☐	Ear ringing
☐	☐	Hearing loss
☐	☐	Infections
☐	☐	Earache
☐	☐	Vertigo

Nose, Throat, Mouth

past	current	
☐	☐	Sinus infections
☐	☐	Allergies
☐	☐	Dry throat
☐	☐	Sore throat
☐	☐	Difficulty swallowing
☐	☐	Bad breath
☐	☐	Bleeding gums
☐	☐	Grinding teeth
☐	☐	Nasal congestion
☐	☐	Nosebleeds
☐	☐	Loss of voice

Signs & Symptoms Cont'd

You can use the back of this page if you need to add any detailed information about any of your health concerns.

Respiratory

past	current	
☐	☐	Difficulty breathing with exertion
☐	☐	Difficulty breathing when lying down
☐	☐	Wheezing
☐	☐	Asthma
☐	☐	Chronic cough
☐	☐	Wet cough
☐	☐	Cough with phlegm
☐	☐	Cough with blood

Cardiovascular

past	current	
☐	☐	High blood pressure
☐	☐	Low blood pressure
☐	☐	Chest pain or tightness
☐	☐	Palpitations
☐	☐	Rapid heart beat
☐	☐	Poor circulation
☐	☐	Swollen ankles
☐	☐	Anemia

Musculoskeletal

past	current	
☐	☐	Joint pain
☐	☐	Weak muscles
☐	☐	Sore/weak knees/ankles
☐	☐	Difficulty walking
☐	☐	Neck/shoulder pain
☐	☐	Upper/mid back pain
☐	☐	Lower back pain
☐	☐	Rib pain
☐	☐	Limited range of motion
☐	☐	Muscle spasms/twitches

Skin

past	current	
☐	☐	Hives
☐	☐	Rashes
☐	☐	Eczema
☐	☐	Psoriasis
☐	☐	Dry skin
☐	☐	Easy bruising
☐	☐	Changes in moles
☐	☐	Itching
☐	☐	Measles
☐	☐	Chicken-pox
☐	☐	Shingles
☐	☐	Acne

Gastrointestinal

past	current	
☐	☐	Nausea
☐	☐	Vomiting
☐	☐	Acid reflux/GERD
☐	☐	Stomach pain
☐	☐	Abdominal bloating
☐	☐	Indigestion
☐	☐	Poor appetite
☐	☐	Gas
☐	☐	Diarrhea
☐	☐	Constipation
☐	☐	Blood in stool
☐	☐	Hemorrhoids
☐	☐	Liver disorder
☐	☐	Gall Stones

Male Health Issues

past	current	
☐	☐	Premature ejaculation
☐	☐	Prostatitis
☐	☐	Impotence

Female Specific

past	current	
☐	☐	Frequent urinary tract infections
☐	☐	Frequent Yeast Infection
☐	☐	Pelvic inflammatory disease
☐	☐	Abnormal PAP smear
☐	☐	Irregular periods
☐	☐	Premenstrual syndrome
☐	☐	Painful menstrual bleeding
☐	☐	Abnormal bleeding
☐	☐	Menopause symptoms
☐	☐	Breast lumps
☐	☐	Cramps
☐	☐	Clotting

Age of Menopause __________

Genitourinary

past	current	
☐	☐	Frequent urination
☐	☐	Painful urination
☐	☐	Urgent urination
☐	☐	Blood in urine
☐	☐	Unable to hold urine
☐	☐	Incomplete urination
☐	☐	Nighttime Urination
☐	☐	Kidney stone
☐	☐	Decreased sex drive

STD

past	current	
☐	☐	Gonorrhea
☐	☐	Chlamydia
☐	☐	Syphilis
	☐	HIV
	☐	Hepatitis A/B/C
	☐	Genital warts
	☐	Herpes: oral/genital