HEALTH HISTORY
CONFIDENTIAL

First Name_______________________ M.I.________ Last Name_________________________________

Address____________________________ City____________________ State______ Zip_____________

Birth Date____________________________ Today's Date_____________________________ Sex: M F

Home Phone______________________________ Alternate Phone_______________________________

Email Address__________________________________ Primary Care Physician____________________

Occupation___________________________________ Employer__________________________________

Emergency Contact_______________________ Phone_____________ Relationship________________

Have you had Acupuncture before? _______________ If yes, when? _____________________________

Please list major complaint(s) or health conditions

____

When did this condition develop?

____

Does anything make it better?

____

Does anything make it worse?

____

Have you ever received treatment for this condition? _______ If yes, when? _______________________

What was the diagnosis? ___________________ What was the treatment? ________________________

List any drug, food or environmental allergies:

____

List medication, vitamins, or herbal/nutritional supplements that you are currently taking:

____

List any major surgeries you have had with dates occurred:

____

List any significant trauma you have experienced:

____

Please check all that apply

SIGNIFICANT ILLNESSES

- ☐ Arthritis
- ☐ Asthma
- ☐ Autoimmune Disease
- ☐ AIDS
- ☐ Cancer
- ☐ Connective Tissue Disease
- ☐ Diabetes
- ☐ Endometriosis
- ☐ Fibromyalgia
- ☐ Gallstones
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Herpes
- ☐ Hypertension
- ☐ Kidney Stones
- ☐ Rheumatic Fever
- ☐ Scoliosis
- ☐ Seizures
- ☐ Thyroid Disease
- ☐ Venereal Disease
- ☐ Other ____________________

Please check any symptoms you currently have or have had in the last year

GENERAL

- ☐ Cold hands/feet
- ☐ Low energy
- ☐ Dizziness
- ☐ Allergies
- ☐ Fatigue
- ☐ Hot flashes
- ☐ Insomnia
- ☐ Spontaneous sweating
- ☐ Night sweating
- ☐ Lack of sweating
- ☐ Recent weight gain
- ☐ Aversion to heat
- ☐ Aversion to cold
- ☐ Weak immune system

NECK AND HEAD

- ☐ Blurred vision
- ☐ Floaters
- ☐ Heaviness in head
- ☐ Headache
- ☐ Cataracts
- ☐ Earache
- ☐ Ear discharge
- ☐ Eye strain
- ☐ Corrected vision
- ☐ Nasal discharge/obstruction
- ☐ Loss of smell
- ☐ Nosebleeds
- ☐ Red/inflamed eyes
- ☐ Ringing in ears
- ☐ Sinus pressure

RESPIRATORY

- ☐ Asthma
- ☐ Persistent cough
- ☐ Coughing blood
- ☐ Shortness of breath
- ☐ Recurrent bronchitis
- ☐ Phlegm production

CARDIOVASCULAR

- ☐ Chest pain
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Irregular heart beat
- ☐ Poor circulation
- ☐ Varicose veins
- ☐ Rib/side pain

GASTROINTESTINAL

- ☐ Abdominal pain
- ☐ Bloating
- ☐ Belching
- ☐ Gas
- ☐ Constipation
- ☐ Diarrhea/loose stools
- ☐ Bloody stools
- ☐ Black stools
- ☐ Poor appetite
- ☐ Heartburn/acid reflux
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Stomach ache
- ☐ Nausea
- ☐ Vomiting
- ☐ Food sensitivites

DIET/LIFESTYLE

- ☐ Vegetarian
- ☐ Healthy diet
- ☐ Eat fried foods
- ☐ Smoke
- ☐ Drink alcohol
- ☐ Drink coffee
- ☐ Eat a lot of sweets
- ☐ Exercise regularly
- ☐ Minimal exercise
- ☐ High stress
- ☐ Have supportive friends/family

GENITOURINARY

- ☐ Dilute urine
- ☐ Dark urine
- ☐ Blood in urine
- ☐ Cloudy urine
- ☐ Burning urination
- ☐ Scanty urine
- ☐ Frequent urination
- ☐ Poor bladder control
- ☐ Urgency to urinate

MUSCULOSKELETAL

Pain, weakness, numbness in:

- ☐ Arms
- ☐ Legs
- ☐ Hands
- ☐ Feet
- ☐ Joints
- ☐ Shoulders
- ☐ Hips
- ☐ Neck
- ☐ Elbows
- ☐ Knees
- ☐ Back
- ☐ Pain all over

SKIN

- ☐ Broken blood vessels
- ☐ Blood not clotting
- ☐ Bruise easily
- ☐ Discoloration
- ☐ Darkness around eyes
- ☐ Swollen lymph nodes
- ☐ Dry skin
- ☐ Acne
- ☐ Brittle nails
- ☐ Dry, brittle hair
- ☐ Premature gray hair
- ☐ Hair loss

NEUROLOGIC

- ☐ Fainting
- ☐ Convulsions
- ☐ Paralysis
- ☐ Stroke
- ☐ Seizures
- ☐ Tremor
- ☐ Clumsiness
- ☐ Drowsiness
- ☐ Vertigo

EMOTIONAL

- ☐ Nervousness
- ☐ Irritability
- ☐ Anger
- ☐ Troubling dreams
- ☐ Weepy
- ☐ Sadness
- ☐ Forgetfulness
- ☐ Mind not clear
- ☐ Anxiety
- ☐ Fear
- ☐ Unrestrained joy
- ☐ Difficulty expressing emotions
- ☐ Depression

MEN ONLY

- ☐ Genital pain
- ☐ Impotence
- ☐ Genital sores
- ☐ Discharge from penis
- ☐ Nocturnal emission
- ☐ Low sexual energy

WOMEN ONLY

- ☐ Abnormal pap smear
- ☐ Bleeding between periods
- ☐ Irregular periods
- ☐ Heavy periods
- ☐ Painful periods
- ☐ Premenstrual tension
- ☐ Breast lumps
- ☐ Low sexual energy
- ☐ Vaginal discharge
- ☐ Post-menopausal
- ☐ Menopausal
- ☐ Uterine prolapse
- ☐ May be pregnant
- ☐ Pain with intercourse