CONFIDENTIAL HEALTH HISTORY

Welcome! Please take the time to fill out this questionnaire fully. Your answers are strictly confidential. If you have any questions, please feel free to ask.

Today's Date _________________

Name _______________________________________ Date/Place of Birth _____________________________

Address____ City ___________ State _______ Zip ____________

Tel: Work _________________________ Home ________________________ Cell ______________________

E-mail _____________________________ Age _______ Height _________ Weight _______ Sex __________

Occupation____________________________________ Referred by __________________________________

Name & Tel# of Physician ____

Emergency Contact Name & Tel# ______________________________________ Relationship _____________

Below, please briefly describe what would you like treated with acupuncture, when this condition(s) developed, how it has affected you, any medical diagnoses, and what kind of therapies you have already tried.

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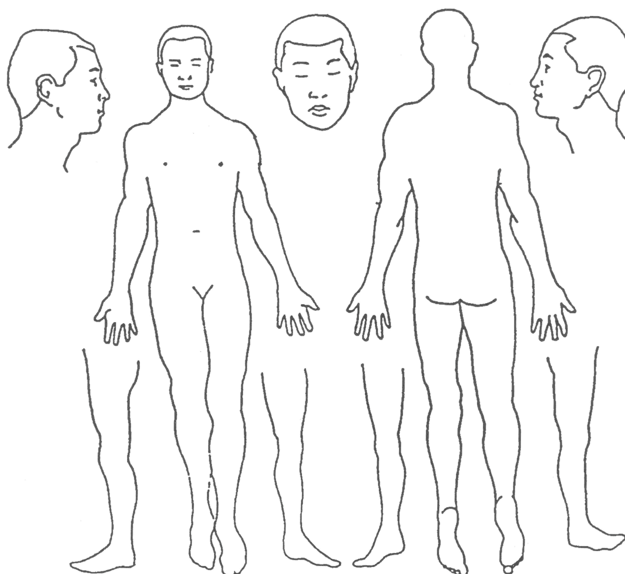
Are you currently pregnant? ___________ Are you presently trying to become pregnant? ____________

Please shade any areas of pain or distress on the diagram below:



Rate your degree of physical distress (0=none, 10=worst possible): 0 1 2 3 4 5 6 7 8 9 10
Rate your degree of emotional distress (0=none, 10=worst possible): 0 1 2 3 4 5 6 7 8 9 10

Medical History

Please check off any current or former conditions and include dates as well as any relevant information.

- ❑ AIDS/HIV ______________________________ any neuropathies? ____________________________________
- ❑ Alcoholism ____
- ❑ Allergies ____
- ❑ Asthma ____ difficulty inhaling ❑ difficulty exhaling ❑
- ❑ Autoimmune disease____
- ❑ Birth complications____
- ❑ Cancer ____
- ❑ Diabetes ________________________________ any neuropathies? ____________________________________
- ❑ Hepatitis A/B/C - please specify ____
- ❑ Heart Disease ____
- ❑ Lyme disease ____
- ❑ Lymph Nodes removed - where? _________________________ can you have injections on that side? ______
- ❑ Pacemaker ____
- ❑ Rheumatic or Scarlet Fever ____
- ❑ Seizures ____
- ❑ Thyroid disease ____
- ❑ Vaccine reactions ____

Please list any serious trauma, broken bones, head injuries, scarring wounds, onset of health changes, recurring, chronic or major illnesses, other relevant events, and ALL surgeries:

Age __________ ____

Age __________ ____

Age __________ ____

Age __________ ____

Age __________ ____

Age __________ ____

Age __________ ____

Age __________ ____

Age __________ ____

Age __________ ____

Age __________ ____

Scars from injury/surgery: ____

Family Medical History Please list major illnesses in your close family such as diabetes, cancer, heart disease, autoimmune, neurological, psychological, orthopedic etc.____

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Medications List all medications (including over-the counter) and herbs you are taking, and why.___________________

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Exercise: What and how often:____

Diet: Restrictions (Vegetarian, Gluten free, etc)?_______________________Since:__________

Food cravings? _______________________ Food intolerances?____________________

Typical breakfast _____________________ Lunch______________________________

Dinner ____________________________Snacks ______________________________

How much and how often do you have the following:

Sugar / Sweets _______________________ Water ___________________________

Artificial sweeteners ___________________ Alcoholic beverages ___________________

Coffee_____________________________ Cigarettes __________ per day __________years

Soda ______________________________ Date quit:____________

How often do you move your bowels: ____

Any problems with bowels? ____

Urination problems or changes? (e.g. frequent, painful, unusual color):__________________

Emotions: How do you feel emotionally?_______________________________________

Major sources of stress: ____

How / where do you hold stress? ____

How is your sleep? ____

Women: Current/past use of birth control pill or other hormone therapies____________________

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IU device, tubal ligation or other similar birth control_____________________________

Age at first menses _____Days between cycles ______Duration of flow ______Date of last menses__________

Usual color/quality of blood_____________________________ Recent changes?______________

Symptoms related to menstrual cycle:____

Number of pregnancies _______ deliveries _______ abortions______miscarriages________________

Pregnancy and delivery complications____

Age at menopause ___________Menopause symptoms:____________________________

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Please **(Circle)** any problem you have now**,** **Underline** items that were severe or chronic in the past

Skin/Hair: dry skin - rashes - itching - acne - eczema - hives - ulcerations - fungal infections - psoriasis - dry hair - dandruff - hair loss - brittle nails - sores on lips or tongue - gum problems – dental abscess – poor teeth

Cardiovascular: pacemaker - fast pulse - slow pulse - chest pressure/pain - shortness of breath - palpitations - arrhythmia - high blood pressure - low blood pressure - cold hands/feet - cold sweats - poor circulation – blood clots - bruise easily - phlebitis - varicose veins - anemia - fatigue/exhaustion - hypoglycemia

GI: abdominal pain - distention/bloating - ulcer - acid reflux - lack of acid - foul breath - frequent belching – frequent gas - irritable bowel - diarrhea/loose stool - constipation - hard stool – blood in stool - mucus in stool - black stool - hemorrhoids - chronic laxative use

Respiratory: chronic cough - coughing blood - asthma/wheezing – freq. strept infections - bronchitis - pneumonia - tuberculosis - shortness of breath - excessive phlegm – freq. colds or flu - nose bleeds - chronic runny nose - chronic stuffy nose – chronic sore throat - post-nasal drip

Sensory: painful/red eyes - see spots/floaters - night blindness – freq. ear infections - poor hearing – ear ringing - poor balance - dizziness/vertigo - TMJ /jaw pain – freq. headache/migraine – motion sickness – tremors/ticks

Women: vaginal itch/burning - freq. yeast infection - low sexual energy - genital sores/pain - unusual discharge

Men: prostatitis – erectile dysfunction – low sexual energy - genital sores/pain - unusual discharge

Other past/current symptoms:_____________________________________Thank you!