



Patient Health History

Thank you for taking the time to complete the following information which will better help me to access your health needs. All information is confidential. I will be happy to answer any questions you may have.

Date ____/____/____	First Name		Last Name	
Gender M / F	Date of Birth ____/____/____	Age	Relationship Status <i>(circle one)</i> Single Married Domestic Partnership Separated Divorced Widowed	
Street Address		City	State	Zip
Phone (Daytime) - Home Work Mobile <i>(circle one)</i>		Alternative Phone - Home Work Mobile <i>(circle one)</i>		
Emergency Contact Name:		Emergency Contact:		
Relationship to you:		Home phone ()		
		Alternate phone ()		
How did you hear about us? <i>(Please circle one and write the name so we can thank them.)</i>				
Current/Past Patient: _____ Doctor: _____ Friend: _____				
Other Healthcare Provider: _____ Advertisement: _____ Other: _____				
Would you like to receive a complementary monthly/quarterly acupuncture newsletter via email? Y N				
Email address: _____				
Employment <i>(Please circle all that apply)</i>		Occupation: _____		
Full-time Part-time Student Retired		Employers Name: _____		
Homemaker Unemployed Self-Employed		How many hours a week do you work/study? _____		

Chief Complaint: *(What you are seeking treatment for today)*

When did it start? _____ How often? _____

What caused this (accident, lifestyle, drug, etc): _____

Describe the severity of it: _____

What treatments have you tried (ice/heat/rest/over-the-counter meds/other)? _____

Temporary Relief? _____ Fixed part of the problem? _____ Caused side effects? _____

Have you sought treatment elsewhere for this (MD, Physical Therapist, other?) _____ When? _____

How does this affect your life? _____

Does it affect *(Circle all that apply)* family work sleep relationships hobbies activities

Other issues you'd like to address:

MEDICAL CONDITIONS Please list conditions/surgeries you have had and year diagnosed		ALLERGIES Medications/Seasonal/Environmental/Food
Year:	Condition/Surgery	
Year:	Condition/Surgery	
Year:	Condition/Surgery	

MEDICATIONS - Please list all prescription medications you use. Include those you may only use occasionally. Remember inhalers, eye drops, nose sprays, OTC pain relievers, laxatives, decongestants, diet aids, birth control, etc.					
Prescription Name	Purpose	How Long	Dose	How often	Last taken

SUPPLEMENTS - Please list all supplements you take. This includes vitamins, herbs, minerals, etc.		
Name	Dose/How long?	How often

Do / Did you smoke tobacco? Y N Length of time _____ Amount _____
 Did you quit? Y N Year quit _____

How often do you partake in the following:

- Alcohol Y N How much per day _____ week _____ Wine/Beer/Alcohol _____
- Marijuana Y N How much per day _____ week _____
- Soda Y N How much per day _____ week _____
- Coffee Y N How much per day _____ week _____
- Black Tea Y N How much per day _____ week _____
- Green Tea Y N How much per day _____ week _____

Rate your commitment to resolving this problem and feeling better. (10 being the most committed) 1 2 3 4 5 6 7 8 9 10	Have you had acupuncture in the past? Y N If yes, where/who/how long ago? _____ Any concerns/fears about the needles? _____
What are your goals of your acupuncture visits? _____ _____ _____	For your general health goals, where are you? <i>Circle one</i> + Beginning to think of changes + Know I need to make some changes + Developing a plan of action + In the process of taking action + Refining my plan of action

PERSONAL MEDICAL & FAMILY HEALTH HISTORY

Please indicate whether the health problem is current with “C” or past “P”. Leave blank those that don’t apply.

	You	Father	Mother	Sibling	Spouse/ Partner	Children	Date
AIDS/HIV							
Alcohol/Drug Abuse							
Anemia							
Anorexia							
Anxiety							
Arthritis							
Asthma/Allergies							
Back Troubles							
Blood disorders							
Bronchitis							
Bulimia							
Cancer							
Cataracts/Glaucoma							
Constipation							
Depression							
Diabetes							
Headaches							
Heart Disease							
Hepatitis							
High Blood Pressure							
Immune Disorders							
Insomnia							
Kidney Disease/stones							
Liver Disorders							
Migraines							
Neck Pain							
Osteoporosis							
Sexually Transmitted Disease							
Suicide							
Stroke							
Thyroid Disorders							
Tobacco							
Weight problems							
Other emotional problems: _____							
Other: _____							

MEN ONLY

Do you experience any of the following:

- Reduced Libido Excessive Libido Impotence Prostate Problems
- Urinary Frequency Premature Ejaculation Discharge Urinary Dribbling
- Genital/ Testicular pain Retention of Urine Rectal Dysfunction

Any other concerns? _____

WOMEN ONLY

Hysterectomy -Ovaries Removed? Y N
Post-menopausal bleeding? Y N
Age of first menses? _____
Age of menopause, if applicable _____

Are you, or could you be pregnant? Y N
Number of: Pregnancies _____ Miscarriages _____
Births _____ Abortions _____

Date of your last period? _____
Are your periods: Short (Less than 28 days) Long (28+ days) Varied Regular
Average number of days _____

Number of days bleeding lasts _____
Number of pads/tampons
on heaviest day _____

Describe Menstrual Flow Heavy Moderate Light

Color of Menstrual Flow Purple Dark Red Bright Red Slightly Reddish Pale Red

Birth Control None IUD Birth Control Pill
 Spermicides Condoms Diaphragm/Sponge

Do you suffer from:

Cramping (*mark as appropriate*)
 Severe Moderate Mild
 Before period During Period After Period

Clotting
 Bright in color Dark in color
 Smaller (pea size or smaller) Larger (dime size or larger)
 Early in your cycle Later in your cycle

Bleeding between periods
 Pelvic inflammatory disease
 Endometriosis
 Mastitis
 Ovarian cysts
 Hot flashes
 Breast cysts
 Infertility
 Yeast infections/Vaginitis/other discharge

Premenstrual Symptoms (*mark as appropriate*)
 Fluid retention Fatigue
 Nausea Irritability
 Breast tenderness Depression
 Fluctuating emotions Rage
 Crying Cravings *If yes, for what* _____

Do you have regular PAP smears? Y N How often? _____ Date of last exam _____

Are you experiencing any low or high sexual desires? Y N Do you have any concerns surrounding this? Y N

MUSCULOSKELETAL

Muscle cramps - Where?

Muscle Pain/Rheumatism - Where?

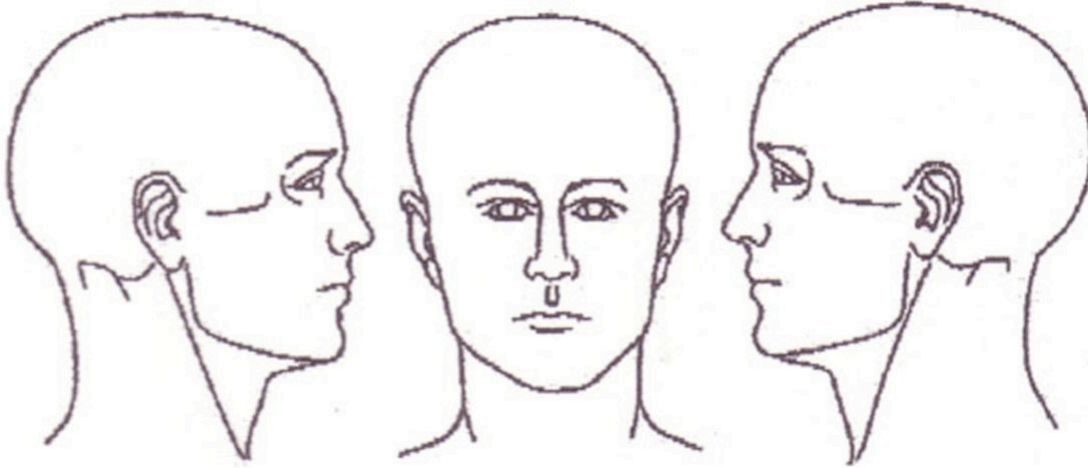
Arthritis - Where?

Joint Swelling - Where?

Tendonitis - Where?

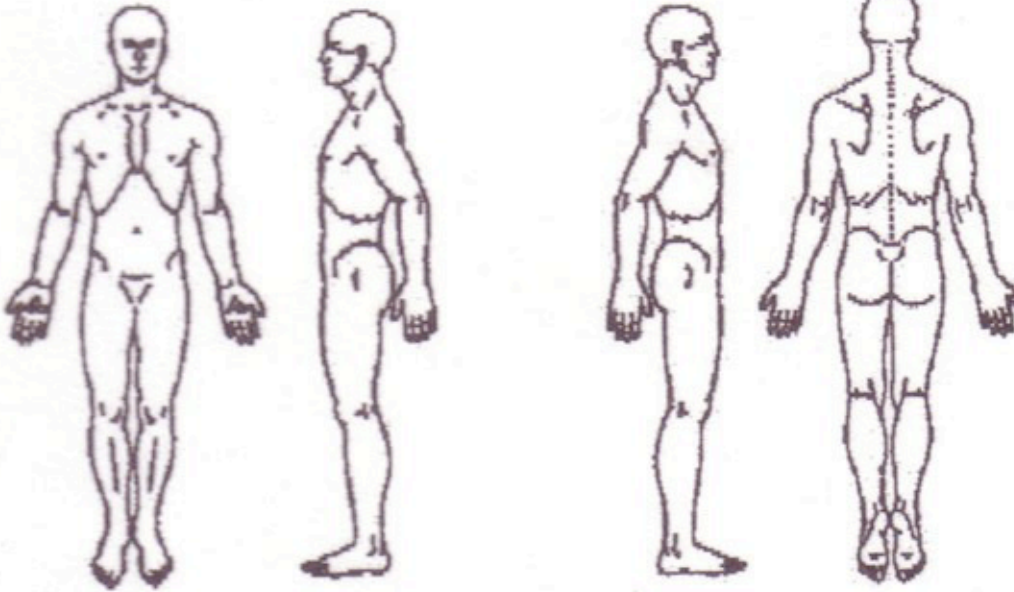
Bursitis - Where?

Please mark problem areas on the diagram:



Describe Pain and Location

- Sharp Burning Aching
 Fixed Radiating Other _____



Describe Pain and Location

- Sharp Burning Aching
 Fixed Radiating Other _____

Describe Pain and Location

- Sharp Burning Aching
 Fixed Radiating Other _____

