Acupuncture Client Health History

Please help us provide you with a complete evaluation by taking the time to fill out this questionnaire carefully. All of your answers will be held absolutely confidential. If you have questions, please ask. If there is anything you wish to bring to our attention that is not asked on this form, please note it in the comments section. Thank you.

Name____Date_______________________

Name of Client's Representative (if applicable)____

Address____Zip Code________________

Phone: Home______________________Cell________________________Work_________________________

Email___________________________________ Occupation_______________________________________

Emergency contact name/phone____

Date of birth_____/_____/_____ Age ________ Referred by____

Physician__________________________________ Address/phone__________________________________

Main problem(s) you would like to address:

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To what extent does this problem affect your daily activities (work, sleep, eating, etc.)

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How long has it been since you first noticed any symptoms?

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Have you been given a diagnosis for the problem by your physician? ☐Y ☐N If so, please describe.

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What kinds of treatment have you tried?

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Have you tried acupuncture or Chinese herbal medicine before? When/why?

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Past Medical History

- ☐ Allergies
- ☐ Diabetes
- ☐ High blood pressure
- ☐ STD
- ☐ Accidents/Trauma
- ☐ Hepatitis
- ☐ Rheumatic fever
- ☐ Thyroid disease
- ☐ Cancer
- ☐ Heart disease
- ☐ Seizures
- ☐ HIV

Please elaborate on checked boxes including dates:

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Family Medical History

Please indicate any significant family medical history:

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Lifestyle

Do you exercise regularly? ☐Y ☐ N If so, please describe

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Describe your average daily diet:____

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Please check any of the following habits that apply. Indicate how much & how often you consume them.

☐ Cigarettes ___________________ ☐ Coffee, tea ___________________ ☐ Alcohol _______________________

Medications taken within the last two months (include vitamins, herbs, etc.)

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Please put a check next to the conditions you have experienced within the **last three (3) months**. Indicate the length of time you have had this condition:

General

- [ ] Bleeding or bruising
- [ ] Weight gain/loss
- [ ] Localized weakness
- [ ] Strong thirst
- [ ] Insomnia
- [ ] Night sweats
- [ ] Disturbed sleep
- [ ] Sweat easily
- [ ] Poor balance
- [ ] Fever or Chills
- [ ] Sudden energy drop

Please elaborate on checked boxes:

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Skin & Hair

- [ ] Acne/pimples
- [ ] Rashes
- [ ] Ulcerations
- [ ] Hives
- [ ] Eczema
- [ ] Recent moles
- [ ] Itching
- [ ] Dandruff
- [ ] Hair loss
- [ ] Changes in hair or skin texture
- [ ] Other ______________________

Please elaborate on checked boxes:

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Head, Eyes, Ears, Nose, & Throat

- [ ] Headaches
- [ ] Migraines
- [ ] Concussion
- [ ] Facial pain
- [ ] Sinus problems
- [ ] Nose bleeds
- [ ] Sores on lips/tongue
- [ ] Jaw clicks
- [ ] Tooth problems
- [ ] Grinding teeth
- [ ] Recurrent sore throat
- [ ] Blurry vision
- [ ] Poor vision
- [ ] Glasses
- [ ] Cataracts
- [ ] Color blindness
- [ ] Night blindness
- [ ] Eye pain
- [ ] Eye strain
- [ ] Spots in front of eyes
- [ ] Poor hearing
- [ ] Earaches
- [ ] Ringing in ears
- [ ] Other _______________________

Please elaborate on checked boxes:

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Cardiovascular

- [ ] Chest pain
- [ ] High blood pressure
- [ ] Difficulty breathing
- [ ] Fainting
- [ ] Swelling of hands/feet
- [ ] Low blood pressure
- [ ] Blood Clots
- [ ] Cold hands or feet

Please elaborate on checked boxes:

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Respiratory

- [ ] Asthma
- [ ] Bronchitis
- [ ] COPD/emphysema
- [ ] Cough
- [ ] Coughing up blood
- [ ] Difficulty breathing when lying down
- [ ] Frequent colds
- [ ] Pain with deep breath
- [ ] Pneumonia
- [ ] Production of phlegm
- [ ] Other________________________________

Please elaborate on checked boxes:

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Gastrointestinal

- [ ] Abdominal pain or cramps
- [ ] Gas
- [ ] Vomiting
- [ ] Hemorrhoids
- [ ] GERD
- [ ] Belching
- [ ] Diarrhea
- [ ] Blood in stool
- [ ] Indigestion
- [ ] Nausea
- [ ] Constipation
- [ ] Rectal pain
- [ ] Poor appetite
- [ ] Changes in appetite

Please elaborate on checked boxes:

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Genito-urinary

- [ ] Frequent urination
- [ ] Unable to hold urine
- [ ] Kidney stones
- [ ] Other___________________
- [ ] Urgency to urinate
- [ ] Blood in urine
- [ ] Impotence
- [ ] Pain during urination
- [ ] Decrease in flow
- [ ] Sores on genitals

- [ ] Do you wake at night to urinate? If so, how often? ____

Please elaborate on checked boxes:

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Female Reproductive & Gynecologic

- [ ] Heavy menses
- [ ] Irregular / unusual menses
- [ ] Menstrual clots
- [ ] Breast tenderness
- [ ] Light menses
- [ ] Painful menses
- [ ] Vaginal discharge
- [ ] Endometriosis
- [ ] Fibroids
- [ ] Bleeding during / after sex
- [ ] Infertility
- [ ] Vaginal dryness

Do you use birth control? ☐Y ☐N If so, what type and how long? ____

Age of first menses ________________ Time between menses ______________ Duration ___________________________

First day of last menses _____________ Miscarriages ☐Y ☐N Abortions ☐Y ☐N

Number of pregnancies _____________ Number of births __________________ Premature births ___________________

Menopause ☐Y ☐N What age?_____________

Please elaborate on checked boxes:

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Male Reproductive

- [ ] Prostate Cancer
- [ ] Painful urination
- [ ] Erectile dysfunction
- [ ] Difficulty urinating
- [ ] Frequent urination
- [ ] Premature ejaculation

Please elaborate on checked boxes:

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Musculoskeletal

- [ ] Neck pain
- [ ] Hand/wrist pain
- [ ] Shoulder pain
- [ ] Back pain
- [ ] Knee pain
- [ ] Hip pain
- [ ] Foot/ankle pain
- [ ] Muscle pain
- [ ] Muscle weakness
- [ ] Other __________________

Please elaborate on checked boxes:

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Neuropsychological

- [ ] Anxiety
- [ ] Depression
- [ ] Bad temper
- [ ] Easily susceptible to stress
- [ ] Areas of numbness
- [ ] Poor memory
- [ ] Concussion
- [ ] Seizures
- [ ] Dizziness
- [ ] Lack of coordination
- [ ] Loss of balance
- [ ] Tremors

Have you ever been treated for emotional problems? [ ] Y [ ] N

Please elaborate on checked boxes:

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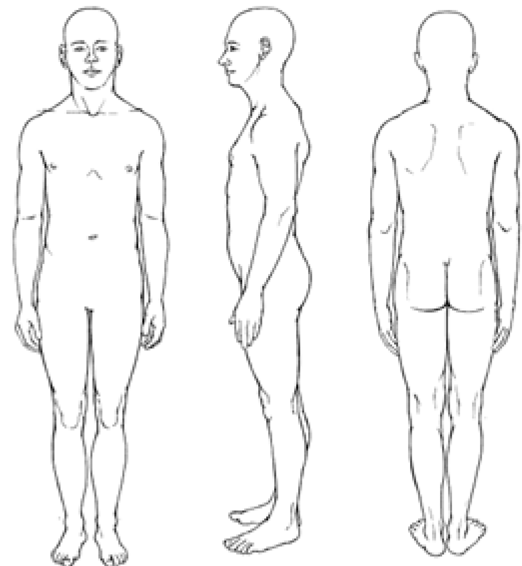
On the figures to the right, please indicate the areas where you carry tension, experience discomfort or hold stress.



On a scale of 0 (no tension) to 10 (high levels of stress) please indicate the amount of tension in your life: __________________

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Any additional information/comments

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All of the information is correct and current to the best of my knowledge, and I will update my health history form with any changes in my health and medication.

______________________________	______________________________	____________
Client's (Representative's) Signature	Indicate relationship if signing for Client	Date