Pin Up Acupuncture
Patient Health History

Name: ____ Date: ______/______/______
(first) (middle) (last)

Date of Birth: ____/____/____ Age: _____ Gender: ____ Marital status: _______ Height: _____ Weight: _____

Address: ____ City:______________________ Zip Code ___________

Best Contact Number: ________________________________ Email Address: _____________________________________

Emergency Contact: __________________________________ Number: ____

Successful health care and preventative medicine are only possible when the practitioner has a complete understanding of the patient physically, mentally and emotionally. Please complete this questionnaire as thoroughly as possible. Print all information and indicate areas of confusion with a question mark. Thank you.

1. Are you currently under the care of a Physician? ___________ For what reason? ____________________________________

Name and phone number of Physician: ____

2. Has your case been referred to an attorney? Y /N Auto Accident? Y/N If Auto, PIP or PI?______ Date of Accident__________

3. Please identify the health concerns that have brought you to Pin Up Acupuncture in order of importance below:

Condition Past Treatment

a. ___________________________ ____

Does it affect Sleep/Work/Other? _____________ What makes it better or worse? __________________________

b. ___________________________ ____

Does it affect Sleep/Work/Other? _____________ What makes it better or worse? ____________________________

c. ___________________________ ____

Does it affect Sleep/Work/Other? _____________ What makes it better or worse? ____________________________

4. If applicable, please list any foods, drugs, or medications you are hypersensitive or allergic to (please include reaction):

____

5. Please list any medications (prescribed and over-the-counter), vitamins, and supplements you are currently taking:

____

6. Do you have any reason to believe you may be pregnant? Y/N If so, how far along are you?______________________

7. Do you have any infectious diseases? Y/N If yes, please identify: _________________________________

8. **Childhood Illness** (please circle any that you have had):

Scarlet Fever Diphtheria Rheumatic Fever Mumps Measles German Measles Chicken Pox

9. **Immunizations** (please circle any that you have had):

Polio Tetanus Rubella/Mumps/Rubella Pertussis Diphtheria Hib Hepatitis B

Others: ____

10. **Hospitalizations and Surgeries:**

Reason	When	Reason	When

11. **X-Rays/CAT Scans/MRI's/Special Studies:**

Reason	When	Reason	When

12. **Emotional** (please circle any experienced now or any that you have experienced in the past):

Mood Swings Nervousness Mental Tension Anxiety Panic Attack

13. **Energy and Immunity** (please circle any experienced now or any that you have experienced in the past):

Fatigue Slow Wound Healing Chronic Infections Chronic Fatigue Syndrome

14. **Head, Eye, Ear, Nose, and Throat** (please circle any experienced now or any that you have experienced in the past):

Impaired Vision Eye Pain/Strain Glaucoma Glasses/Contacts Tearing/Dryness

Impaired Hearing Ear Ringing Earaches Headaches Sinus Problems

Nose Bleeds Frequent Sore Throats Teeth Grinding TMJ/Jaw Problems Hay Fever

15. **Respiratory** (please circle any experienced now or any that you have experienced in the past):

Pneumonia Frequent Common Colds Difficulty Breathing Emphysema Persistent Cough Pleurisy

Asthma Tuberculosis Shortness of Breath Other Respiratory Problems: __________________________

16. **Cardiovascular** (please circle any experienced now or any that you have experienced in the past):

Heart Disease   Chest Pain   Swelling of Ankles   High Blood Pressure

Palpitations/Fluttering   Stroke   Heart Murmurs   Rheumatic Fever   Varicose Veins

17. **Gastrointestinal** (please circle any experienced now or any that you have experienced in the past):

Ulcers   Changes in Appetite   Nausea/Vomiting   Epigastric Pain   Passing Gas   Heartburn

Belching   Gall Bladder Disease   Liver Disease   Hepatitis B or C   Hemorrhoids   Abdominal Pain

18. **Genito-Urinary Tract** (please circle any experienced now or any that you have experienced in the past):

Kidney Disease   Painful Urination   Frequent UTI   Frequent Urination   Heavy Flow

Kidney Stones   Impaired Urination   Blood in Urine   Frequent Urination at Night

19. **Female Reproductive/Breasts** (please circle any experienced now or any that you have experienced in the past):

Irregular Cycles   Breast Lumps/Tenderness   Nipple Discharge   Heavy Flow

Vaginal Discharge   Premenstrual Problems   Clotting   Bleeding Between Cycles

Menopausal Symptoms   Difficulty Conceiving   Painful Periods   PMS

20. **Menstrual/Birthing History:**

1. Age of First Menses: _______   8. # of Pregnancies: ________   7. Date of last PAP: _______

2. # of Days of Flow: _______   5. # of Births: ________   8. Date last period began:_______

3. Length of Cycle: _______   6. # of Premature births: _____   9. Age at Menopause: ________

21. **Male Reproductive** (please circle any experienced now or any that you have experienced in the past):

Sexual Difficulties   Prostrate Problems   Testicular Pain/Swelling   Penile Discharge

22. **Musculoskeletal** (please circle any experienced now or any that you have experienced in the past):

Neck/Shoulder Pain   Muscle Spasms/Cramps   Arm Pain   Upper Back Pain   Mid Back Pain

Low Back Pain   Leg Pain   Joint Pain (if so,where?):____

23. **Neurologic** (please circle any experienced now or any that you have experienced in the past):

Vertigo/Dizziness   Paralysis   Numbness/Tingling   Loss of Balance   Seizures/Epilepsy

24. **Endocrine** (please circle any experienced now or any that you have experienced in the past):

Hypothyroid   Hypoglycemia   Hyperthyroid   Diabetes Mellitus   Night Sweats   Feeling Hot or Cold

25. **Other** (please circle any experienced now or any that you have experienced in the past):

Anemia   Cancer   Rashes   Eczema/Hives   Cold Hands/Feet   Acne   Psoriasis   Fungal Infection

Is there anything else we should know? ____

26. **Lifestyle:**

a. Do you typically eat at least three meals per day?Y/N   If no, how many? ____________________

b. Are you on any restricted diet? Y/N   If so, what and for how long? ___________________________________

c. How much water do you drink daily? ____

d. Exercise routine: ____

e. Spiritual practice: ____

f. How many hours per night do you sleep? ________   Do you wake rested?   Y   N

g. Occupation: ___________________________Employer: ____________________   Hours/Week: ______

f. Nicotine/Alcohol/Marijuana/Caffeine Use: ____

h. Have you experienced any major traumas?   Y   N   Explain: ___________________________________

____

i. Interests and hobbies: ____