Family Acupuncture
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Acupuncture Health History Form

Please take time to fill out this questionnaire carefully. The information you provide will assist us in formulating a complete health profile for you. All of your answers are absolutely confidential. If you have questions, please ask.

Name:_____ Date:_____

Address:_____

City:_____ State:_____ Zip:_____

Home Phone:_____ Work Phone:_____

Mobile Phone:_____ E-mail:_____

Date of Birth:_____ Age:_____ Marital Status:_____

Occupation:_____ Referred by:_____

Physician:_____ Phone:_____

Physician's Address_____

In Emergency Notify_____ Phone:_____

Main Complaint (symptoms, diagnosis, duration, etc.)_____

_____

Significant Trauma (physical, emotional) & **Surgeries** (please include date of procedure)_____

_____

Allergies (chemical, environmental, food, drugs, etc.)_____

_____

Medications/Vitamins/Supplements/Herbs *please attach an additional page if necessary*_____

_____

Birth History (prolonged labor, forceps delivery, complications, etc.)_____

_____

Exercise: Days per week_____ Length of workout_____ Type of Activity _____

Typical Diet: Breakfast_____ Lunch_____ Dinner_____

Snacks_____Caffeinated Drinks (what/how many)_____ Alcohol per week _____

Personal History

Please check any conditions or symptoms you have or have had.

□Arthritis	□Liver/Gall Bladder Disease	□Stroke	□Heart Disease
□High/Low Blood Pressure	□Hypo/Hyperglycemia	□Kidney Disease	□High Cholesterol
□Cancer	□Diabetes	□Food Allergies/Intolerance	□IBS/Diverticulitis
□Ulcer	□Seizures	□Hepatitis	□Raynaud's Disease
□Chronic Fatigue	□Anemia	□Thyroid Imbalance	□Respiratory Allergies
□Alcoholism	□Lyme Disease	□Chronic Pain Condition	□Impotence
□Gastritis/Pancreatitis	□Asthma	□Infertility	□Emphysema

Family Medical History

Please check any condition that applies to your immediate family.

□Diabetes	□Seizures	□Cancer
□High blood pressure	□Allergies	□Stroke
□Other_____	□Heart Disease	□Asthma

Please Check if you have had any of these items listed below in the last 3 months.

General Symptoms

□Poor Appetite	□Poor Sleep	□Fatigue	□Fever
□Heavy appetite	□Dental/gum problems	□Sweat Easily	□Night Sweats
□Strongly like cold drinks	□Bodily heaviness	□Poor Balance	□Cold hands or feet
□Strongly like hot drinks	□Weight loss/gain	□Peculiar tastes/ smells	□tremors
□Muscle Weakness/Fatigue	□Sudden energy drop	□Change in appetite	□ Bleed/Bruise easily

Skin and Hair

□Rashes	□Ulcerations	□Hives/Allergic Dermatitis	□Itching
□Eczema/Psoriasis	□Dandruff	□Loss of hair	□Recent moles
□Skin discoloration	□Acne	□Change in texture	□Face flushing
□Dermatitis	□Warts	□Fungal Infections	

Head, Eyes, Ears, Nose and Throat

□Eye Strain	□ Ringing in Ears	□Headaches	□Facial Pain
□Eye Pain	□ Poor Hearing	□Difficulty swallowing	□Jaw Clicks/locks
□Color blindness	□ Earaches	□Grinding teeth	□Dizziness
□Cataracts	□Recurrent sore throat/Cold	□Sores on lips/tongue	□Blurred Vision
□Poor Vision	□Dental Problems	□Nose bleeds	
□Spots in front of eyes	□Migraines	□Sinus Problems	

Cardiovascular

□Chest pain or pressure	□swelling of hands/feet	□Blood clots	□Phlebitis
□High blood Pressure	□Varicose/spider veins	□Pressure in chest	□ Shortness of breath
□Low blood pressure	□Spontaneous sweating	□Dizziness	
□Irregular heart beat	□Palpitations at rest	□Fainting	

Respiratory

□Cough/Wheezing □Pain with deep inhalation □Bronchitis □Difficult breathing laying down
□Pneumonia □Asthma □Difficult inhale □Production of phlegm
□Coughing blood □Tight sensation in chest □Difficult exhale

Gastrointestinal

□Nausea □Vomiting □Diarrhea □Constipation
□Gas □Belching □Black stools □Blood in stool
□Indigestion □Bad breath □Rectal Pain □Mucous in stool
□Bloating/Edema □Chronic laxative use □Loose stools □Abdominal pain/Cramps
□Changes in appetite □Acid reflux//GERD □Hernia □ Hemorrhoids
□Excessive appetite □Significant thirst □IBS/Crohn's Dis ease

Genito-Urinary

□Pain on urination □Frequent urination □Blood in urine □Impotence
□Unable to hold urine □Kidney stones □Scanty urine flow □Nocturnal emission
□Urgent urination □Sores on genitals □Copious urine flow □Premature ejaculation
□Burning urination □Decreased libido □Prostatitis □Dribbling after urination
□Urinary tract infection □Pain in testicles □Herpes □Infections
□Night urination - How often?_____ What times?_____

Gynecological/Reproductive

□Difficult/Painful intercourse □Endometriosis □Date of last menses_____
□Vaginal Dryness □Uterine Fibroids □Date of last PAP/Pelvic_____
□Vaginal sores □Fibrocystic breast tissue □Number of pregnancies_____
□Vaginal Discharge □Polycystic Ovarian Syndrome □Number of ectopic pregnancies_____
□Infertility □PMS □Number of live births_____
□Irregular Menstruation □Painful menstruation □Number of miscarriages_____
□Ovarian cysts □Age of first menses_____ □Number of abortions_____
□Do you practice birth Control?_____ What type?_____ For how long?_____

Musculoskeletal

□Neck pain □Knee pain □Limited range of motion □Bursitis
□Shoulder pain □Hand/wrist pain □Sprains/Strains □Carpal tunnel
□Hip pain □Foot/ankle pain □Muscle pain □Tendonitis
□Back pain □Muscle weakness □Sciatica □Rotator cuff

Neuropsychological

□Seizures □Nervousness □Bad temper/irritable □ADD/ADHD
□Lack of coordination □Depression □Considered/attempted suicide □Easily stressed
□Anxiety/panic attacks □Seasonal Affective Disorder □Seeing a therapist □ Poor memory
□Areas of numbness

On the back of this form please inform us of any other problems you would like to discuss.