

The Acupuncture Office Health History

Name	Day Phone	Night Phone	Cell Phone
Street Address	City, State		Zip code
E-mail	Height	Weight	Date of Birth Profession
Emergency Contact Name	Emergency Phone		Marital Status
Referred by	Primary Care Physician		Physician phone number

Reason for visit today:	How long have you had this condition?	Sudden or Gradual onset?	Is the problem getting worse?
What seemed to be the cause?	What seems to make it better?	What seems to make it worse?	
Have you been given a western medical diagnosis for this problem: If so, what is it?			
What treatments have you tried? Were they helpful?			

Past & Present Medical History (please check all that are applicable)			
<input type="checkbox"/> AIDS/HIV	<input type="checkbox"/> Gout	<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Trauma (list) _____
<input type="checkbox"/> Alcoholism	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Scarlet Fever	_____
<input type="checkbox"/> Allergies	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Seizures	_____
<input type="checkbox"/> Appendicitis	<input type="checkbox"/> Herpes	<input type="checkbox"/> Stroke	_____
<input type="checkbox"/> Arteriosclerosis	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Surgery (list) _____	_____
<input type="checkbox"/> Asthma	<input type="checkbox"/> Measles	_____	<input type="checkbox"/> Ulcer
<input type="checkbox"/> Cancer	<input type="checkbox"/> Multiple Sclerosis	_____	<input type="checkbox"/> Venereal Disease
<input type="checkbox"/> Chicken Pox	<input type="checkbox"/> Mumps	_____	<input type="checkbox"/> Whooping Cough
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Pacemaker	_____	<input type="checkbox"/> Other (list) _____
<input type="checkbox"/> Emphysema	<input type="checkbox"/> Pleurisy	_____	_____
<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Pneumonia	_____	_____
<input type="checkbox"/> Goiter	<input type="checkbox"/> Polio	<input type="checkbox"/> Thyroid Disorder	_____
Current Medications (last two months)			
Current Vitamins, supplements, herbs (last two months)			

Diet & Typical Daily Menu (please list)					
<input type="checkbox"/> Large Appetite	<input type="checkbox"/> Coffee (cups/day _____)	<input type="checkbox"/> Sugar	<input type="checkbox"/> Salty Food		
<input type="checkbox"/> Small Appetite	<input type="checkbox"/> Soda (glasses/day _____)	<input type="checkbox"/> Artificial Sweetener	<input type="checkbox"/> Thirst (glasses/day ____)		
Breakfast	Snack	Lunch	Snack	Dinner	Snack

Lifestyle		Regular Exercise <input type="checkbox"/> yes <input type="checkbox"/> no	
<input type="checkbox"/> Alcohol	<input type="checkbox"/> Marijuana	<input type="checkbox"/> Stress	Type _____ frequency _____
<input type="checkbox"/> Tobacco	<input type="checkbox"/> Other drugs	<input type="checkbox"/> Occupational Hazard	Type _____ frequency _____
General Feelings			
<input type="checkbox"/> Trouble falling asleep	<input type="checkbox"/> Cold hands/feet	<input type="checkbox"/> Muscle Cramps	<input type="checkbox"/> Peculiar taste (describe) _____
<input type="checkbox"/> Wake at night	<input type="checkbox"/> numbness/tingling	<input type="checkbox"/> Bleed/Bruise Easily	_____
<input type="checkbox"/> Heavy Sleep	<input type="checkbox"/> Chills	<input type="checkbox"/> Dizziness/Vertigo	_____
<input type="checkbox"/> Dream-disturbed sleep	<input type="checkbox"/> Night Sweats	<input type="checkbox"/> Strongly Prefer cold drinks	_____
<input type="checkbox"/> Fatigue	<input type="checkbox"/> Sweat Easily	<input type="checkbox"/> Strongly Prefer warm drinks	_____
<input type="checkbox"/> Lack of strength	<input type="checkbox"/> Recurrent Fever		
<input type="checkbox"/> Body feels heavy	<input type="checkbox"/> Recent Weight gain/loss		
Head, Eyes, Ears, Nose, Throat			
<input type="checkbox"/> Glasses/contacts	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Sinus Problems	<input type="checkbox"/> Ringing in Ears
<input type="checkbox"/> Eye Strain	<input type="checkbox"/> Cataracts	<input type="checkbox"/> Excess Mucus (color) _____	<input type="checkbox"/> Concussion
<input type="checkbox"/> Eye Pain	<input type="checkbox"/> Facial Pain		<input type="checkbox"/> Headaches
<input type="checkbox"/> Red Eyes	<input type="checkbox"/> TMJ	<input type="checkbox"/> Frequent Nosebleeds	<input type="checkbox"/> Migraines
<input type="checkbox"/> Dry Eyes	<input type="checkbox"/> Grinding Teeth	<input type="checkbox"/> Frequent Sore throat	<input type="checkbox"/> Neck Pain
<input type="checkbox"/> Itchy Eyes	<input type="checkbox"/> Gum Problems	<input type="checkbox"/> Swollen Glands	<input type="checkbox"/> Limited Range Turning
<input type="checkbox"/> Blurred Vision	<input type="checkbox"/> Sores on lips or tongue	<input type="checkbox"/> Enlarged Thyroid	<input type="checkbox"/> Other head/neck _____
<input type="checkbox"/> See spots/floaters	<input type="checkbox"/> Dry mouth	<input type="checkbox"/> Feeling of lump in throat	
<input type="checkbox"/> Night Blindness	<input type="checkbox"/> Excess Saliva	<input type="checkbox"/> Poor Hearing	
Respiratory			
<input type="checkbox"/> Shortness of Breath	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Coughing Blood	<input type="checkbox"/> Cough → <input type="checkbox"/> Dry <input type="checkbox"/> Wet
<input type="checkbox"/> Tightness in Chest	<input type="checkbox"/> Difficulty Breathing when lying down	<input type="checkbox"/> Asthma	<input type="checkbox"/> Cough mucus → <input type="checkbox"/> thick <input type="checkbox"/> thin
<input type="checkbox"/> Other _____		<input type="checkbox"/> Wheezing	mucus color _____
Cardiovascular			
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Fast Heartbeat	<input type="checkbox"/> Irregular Heartbeat	<input type="checkbox"/> Heart Palpitations
<input type="checkbox"/> Low Blood Pressure	<input type="checkbox"/> Chest Pain	<input type="checkbox"/> Phlebitis/Blood Clots	<input type="checkbox"/> Other _____
	<input type="checkbox"/> Fainting	<input type="checkbox"/> Cold Hands/Feet	
Gastrointestinal			
<input type="checkbox"/> Nausea	<input type="checkbox"/> Bloating	<input type="checkbox"/> Diarrhea	Bowel Movements
<input type="checkbox"/> Vomiting	<input type="checkbox"/> Gas	<input type="checkbox"/> Constipation	Frequency _____/Day
<input type="checkbox"/> Hiccups	<input type="checkbox"/> Intestinal Pain/Cramping	<input type="checkbox"/> Laxative Use	Color _____
<input type="checkbox"/> Bad Breath	<input type="checkbox"/> Hemorrhoids	<input type="checkbox"/> Black Tarry Stools	Texture _____
<input type="checkbox"/> Acid Regurgitation	<input type="checkbox"/> Itchy Anus	<input type="checkbox"/> Blood in Stools	
<input type="checkbox"/> Anal Fissure	<input type="checkbox"/> Burning Anus	<input type="checkbox"/> Mucus in Stools	
Genito-Urinary			
<input type="checkbox"/> Painful Urination	<input type="checkbox"/> Kidney Stones	Urination: _____	<input type="checkbox"/> Venereal Disease
<input type="checkbox"/> Frequent Urination	<input type="checkbox"/> Bedwetting	Frequency _____/Day	<input type="checkbox"/> Increased Libido
<input type="checkbox"/> Urgent Urination	<input type="checkbox"/> Unable to hold Urine	Color: _____	<input type="checkbox"/> Decreased Libido
<input type="checkbox"/> Incomplete Urination	<input type="checkbox"/> Wake to Urinate	Unusual Smell _____	<input type="checkbox"/> Impotence
	<input type="checkbox"/> Blood in Urine		<input type="checkbox"/> Premature Ejaculation
Skin & Hair			
<input type="checkbox"/> Hives	<input type="checkbox"/> Rashes	<input type="checkbox"/> General Itching	<input type="checkbox"/> Hair Loss
<input type="checkbox"/> Ulcerations	Color _____	<input type="checkbox"/> Fungal Infection	<input type="checkbox"/> Change in hair/skin texture
<input type="checkbox"/> Psoriasis	<input type="checkbox"/> Itchy	<input type="checkbox"/> Eczema	<input type="checkbox"/> Dandruff
	<input type="checkbox"/> Feel Warm	<input type="checkbox"/> Acne	<input type="checkbox"/> Dry/Brittle Hair
Other Hair or Skin Problems: _____			
Neurology – Psycho - Emotional			
<input type="checkbox"/> Seizures	<input type="checkbox"/> Poor Memory	<input type="checkbox"/> Phobias	<input type="checkbox"/> Sexual Abuse Survivor
<input type="checkbox"/> Numbness	<input type="checkbox"/> Depression	<input type="checkbox"/> Easily Stressed	<input type="checkbox"/> Physical Abuse Survivor
<input type="checkbox"/> Tics	<input type="checkbox"/> Anxiety	<input type="checkbox"/> Easily Frustrated	<input type="checkbox"/> Verbal Abuse Survivor
<input type="checkbox"/> Tingling	<input type="checkbox"/> Irritable	<input type="checkbox"/> Seeing a Therapist	<input type="checkbox"/> Considered/Attempted Suicide
Other (specify): _____			

Gynecology

Uterine Fibroids Ovarian Cysts Fibrocystic Breasts Date Last Pap Smear _____

Menstrual: Date of last period _____

Age menses began ____

Menstrual Cycle length _____

Period Length _____

Flow: Heavy

Light

Clots

Color: Light red

Dark red

Brown

Fatigued

Spotting between periods

PMS - mood swings

Pain between periods

Headaches

Low back pain

Cramping

Pregnancies/Childbirth

Children _____

Miscarriages _____

Abortions _____

Excessive blood loss

Caesareans _____

Other difficulties

Menopause

Began at what age? ____

Hot flashes

Night sweats

Insomnia

Mood swings

Musculoskeletal

**Please mark on the diagram
areas of discomfort**

Sharp Pain

Dull Pain

Constant Pain

Shooting Pain

Please rate the pain intensity
on a scale of 1 → 10

What decreases the pain?

What causes the pain to increase?

Tingling

Itching

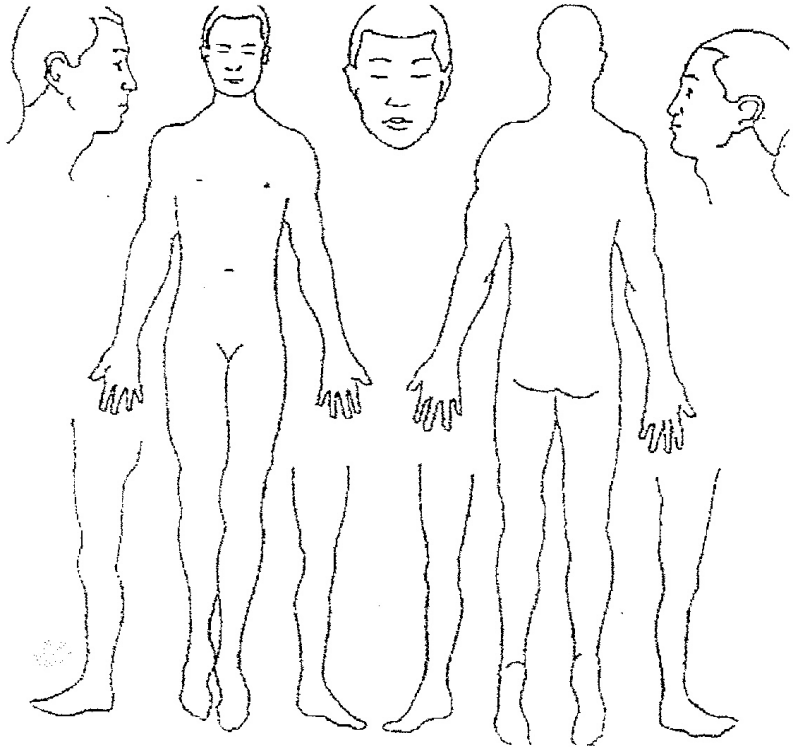
Numbness

Neuropathy

Tension/Tightness

Limited Range of Motion

Limited Use



Please note any other information you feel is necessary:

