ACUPUNCTURE HEALTH HISTORY

Patient Name: _____ Date: _____

Address: _____ City: _____ Postal Code: _____

Birth Date: _____ Age:_____ Height: _____ Weight: _____

Marital Status: _____ Occupation: _____

Employer: _____ Insurance Co: _____

Phone: _____ Cell: _____ Work: _____

Email: _____

Emergency Contact: _____Referred By: _____

Your Main Health Concern (please describe your experience:) _____

_____

_____

_____

Do you have a diagnosis by an M.D./Specialist? Yes No Do you have scans/tests/lab results? Yes No

What other forms of treatment have you experienced? _____

_____

Have you experienced a Traditional Chinese Medicine Acupunture session? Yes No

Please list prior traumas/surgeries with dates: _____

_____

Family Medical History (please describe your parents, grandparents, siblings health conditions): _____

_____

_____

Please list any allergies/food sensitivities: _____

Please list all medications (including vitamins, herbs, homeopathics) you are currently taking: _____

_____

Do you exercise? Yes No How much/How often? : _____

Number of alcoholic beverages/week: _____ Do you smoke? Yes No

Please list any additional drugs you take: _____

Please check if you experience pain/numbness in any of the following:

___ neck
___ shoulders
___ arms/elbows
___ wrist/hands
___ knees
___ feet

___ leg/calf cramps
___ muscle weakness
___ muscle spasms
___ thighs
___ herniated disc
___ hips

___ poor posture
___ sciatica
___ bursitis
___ chest/ribs
___ scoliosis
___ headaches

___ low back pain
___ swollen joints
___ rheumatoid arthritis
___ numbness in toes
___ numbness in fingers
___ degenerative disc

Please check if you are experiencing any of the following symptoms:

___ lack of appetite
___ difficult digestion
___ hiccups
___ excessive appetite
___ abdominal pain
___ heartburn/acid reflux
___ loose stools
___ hemorrhoids
___ recent antibiotics
___ diarrhea
___ colitis
___ constipation
___ diverticulitis
___ vomiting
___ belching
___ tendency towards obsession/compulsion

___ insomnia
___ angina
___ frequent crying
___ heart palpitations
___ chest tightness
___ dry eyes
___ cold hands/feet
___ anxiety
___ dry skin
___ dry hair
___ nightmares
___ poor memory
___ dry mouth
___ mentally restless
___ difficult concentration
___ mouth/gum sores

___ low back tightness
___ urinary pain
___ knee pain
___ frequent urination
___ hearing loss
___ kidney stones
___ tinnitus (high or low ringing)
___ low libido
___ hair loss
___ sciatica
___ coldness in ankles/back/knees

___ cough
___ shortness of breath
___ decreased sense of smell
___ hay fever
___ asthma
___ skin eruptions
___ rhinitis
___ sinus infection
___ post nasal drip
___ bronchitis
___ tendency to catch colds easily

___ eye problems
___ jaundice
___ easily angered
___ breast tenderness/lumps
___ difficulty making decisions
___ gall stones
___ depression
___ light coloured stools
___ spasms/twitching muscles
___ sighing
___ pain/discomfort in lower ribs
___ PMS
___ soft/brittle nails

___ fatigue
___ dizziness
___ high cholesterol
___ sadness/grief
___edema
___ nosebleeds
___ thyroid disorder
___ restless legs at night
___ blood in stool
___ tendency to faint
___ high blood pressure
___ joint stiffness
___ black tarry stool
___ sudden weight loss
___ low blood pressure
___ tremors/imbalance
___ thirsty
___ difficulty to stop bleeding
___ lack of thirst

_____
SIGNATURE OF PATIENT/GUARDIAN

_____
DATE

FOR WOMEN ONLY:

First Period: _____
Menopause: _____
Number of days in cycle: _____
Number of days of flow: _____
Heavy/Med/Light flow: _____
Density: _____
Clotting: _____
Colour: _____
Cramps? YES NO
When: _____
Where: _____
Other symptoms related to menses
(check all that apply)
___ discharge
___ vaginal dryness
___ nausea
___ headache
___ bloating
___ constipation
___ diarrhea
___ swollen breasts
___ ravenous appetite
___ no appetite
___ hot flashes
___ insomnia
___ mood swings
___ night sweats
___ increased libido
___ decreased libido

Are you pregnant? YES NO
Trying? YES NO
Number of:
Pregnancies: _____
Live births: _____
Miscarriages: _____
Abortions: _____
Date/Results of last:
PAP: _____
Mammogram: _____
Bone: _____

FOR MEN ONLY:

Last prostate exam: _____
PSA results: _____
Urination frequency: _____
Urine colour: _____
Check all that apply:
___ delayed urine stream
___ dribbling of urine stream
___ urinary retention
___ impotence
___ groin aches
___ testicular pain
___ back pain
___ premature ejaculation
___ rectal dysfunction