HEALTH HISTORY INFORMATION

NAME:---------- D.O.B.----------
EMAIL:----------
ADDRESS:----------
PHONE:----------
PRIMARY CARE PHYSICIAN:----------

Health Concerns for which you are seeking treatment:

List any allergies:_____

Medications/Supplements/Herbs:

_____
_____

-Electronic devices or implants? Yes / NO
-Have you ever fainted? Yes / No
-Are you anxious about your acupuncture treatment? Yes / No
Females: Are you or could you be pregnant?_____
Birth Control?_____Years taking birth control_____

Typical Diet: please list what you had yesterday (or typically) for the following
Breakfast
Lunch
Dinner
Snacks

Exercise: Type and Frequency:

_____

Please circle the areas that you feel satisfied with in your life:

Romantic relationships	Work and Career
Friendships	Home life
Hygiene	Financial Security
Diet	Exercise

OCCUPATION (please describe your daily activities at work below)

_____

Level of stress (at work) on a scale of 1-10: _____
Level of stress in general on a scale of 1-10:_____

FAVORITES: Color_____ Season _____ Food_____

What are your treatment goals? What would you like to achieve? Please list below:

SLEEP

Hours per night: _____

Time to bed: _____ Time awake:_____

Restful sleep?_____

Circle all that apply

DREAMS / NIGHTMARES / WAKING OFTEN / NIGHTTIME URINATION / RESTLESS SLEEP / LIGHT SLEEPER/ CAN' T WAKE IN THE AM EASILY FEELS LIKE YOU ARE FALLING / WAKE AT CERTAIN TIME :_____

Energy Levels (1-10)_____ Time of day that energy's lowest_____

Daily Bowel Movements? Yes / No

Do you eat or drink any of the following at least once per day? Circle all that apply.

Coffee / Tea / Beer / Wine / Water / Liquor / Juice / Soda / Sugar, sweets / Bread/ Meat / Veggies / Fruits / Cereals / Artificial sweetners / Processed foods / Iced water or iced beverages / Frozen foods / Microwaved foods / Local Foods

Circle all that apply

General

Night sweats *Localized weakness *Bleed or bruise easily *Peculiar tastes or smells *Edema *Poor sleeping *Tremors*Poor balance*Weight change *profuse sweating *history of fevers *always hot *always cold *pain in low back *pain in jaw *pain in joints *pain in neck SCALE OF PAIN 1-10 _____

Skin & Hair

Rashes* Itching* Ulcerations *Eczema* Oozing skin lesion* Hives *Loss of hair *dandruff *dry skin *oily skin

EENT

Dizziness * Migraines *Headaches *Blurry vision *Cataracts *Earaches *Swollen lymph nodes
Ear discharge *Nose bleeds *Sinus congestion *Concussions *Recurrent sore throats *Dry Throat or Mouth

Cardiovascular

High blood pressure *Low blood pressure *Chest pain *Palpitations *Vericose veins
Swelling of hands/feet* Blood clots *Cold hands *Cold feet*High Cholesterol

Respiratory

Asthma/wheezing * Phlegm *Coughing blood *Pneumonia *Bronchitis (history of)

Gastrointestinal

Nausea *Vomiting *Diarrhea *Constipation *Blood in stools *Black stools *light colored stools *Abdominal pain Rectal pain *Hemorrhoids *Abdominal cramping *Heartburn *Bloating after eating *no appetite *big appetite *bad breath *acne *allergies to certain foods *gas *consistent loose stool

Genito-Urinary

Pain on urination *Urgency to urinate *Frequent urination *Blood in urine *Decrease in flow *Dribbling *Kidney Stones *Impotency *Change in sex drive * Sores on genitals *Low libido *High libido *Nighttime urination

Neuropsychological

Seizures *Numbness * Weakness *Vertigo *Floaters in vision *Lack of coordination *Depression
Loss of balance *Poor memory *Anxiety *History of Substance abuse *Thoughts of suicide *PTSD
Diagnosed Mental Illness?:_____

Please list MAJOR SURGERIES below or on the back: (year and type of surgery)

Do you carry any blood-borne or contagious illnesses?

_____

Do you resonate with any of these feelings listed below on a regular basis?
Happiness/Joy
Sadness/Sorrow
Frustration/Irritability
Fear/Anxiety
Worry/overthinking

List three of your greatest attributes or things you admire about yourself the most (ie. you're a good listener, you are an advocate, you are laid back)

List three things about yourself that you would like to change or work on

List three hobbies/or favorite activities

Do you enjoy your work?

If you could do anything in the world and not have to worry about money, what would you do?

Give me a brief history/timeline below on your life, major events, illnesses, major accomplishments, relationships, traumas, anything you feel is relevant. Please use the other side of the page if needed.