Classic Acupuncture
Health History

Name:_______________________________________ Date:_______________

Address:______________________________City:____________________Zip:________

Home Phone:___________________________Cell Phone:________________________________

Email:__________________________________Age:_________Date of Birth________________

Martial Status:_______________________Referred by:__________________________________

Occupation:____________________________Physicain:__________________________________

In Emergency Notify:_________________________________Phone:_______________________

Reason for visit ____

____

Surgeries (please include date of procedure)____

____

____

Allergies (chemical, environmental, food, drug, etc.)____

____

Medication (names & dosages) Please attach an additional page if necessary.

____

____

Vitamins/Supplements/Herbs ____

____

Exercise

Days per week________Length of workout_________Type of Activity__________________________

Diet

Meals per day________Snacks________Caffeinated Drinks________Alcohol per week__________

What makes your condition better? (Rest, movement, heat, cold, etc.)

____

____

What makes your condition worse? (stress, fatigue, hunger, heat, damp days, etc.)

____

____

Personal History - Please check any conditions or symptoms you have now

Use a star symbol for any symptom or condition you have had in the past year

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

General

☐ Poor Appetite	☐ Poor Sleeping	☐ Fatigue	☐ Fevers
☐ Night Sweats	☐ Sweats Easily	☐ Tremors	☐ Cravings
☐ Poor Balance	☐ Bruise Easily	☐ Weight loss/gain	☐ Muscle Weakness

Skin and Hair

☐ Rashes	☐ Ulcerations	☐ Hives	☐ Allergic Dermatitis
☐ Eczema	☐ Psoriasis	☐ Loss of hair	☐ Acne
☐ Face Flushing	☐ Dermatitis	☐ Warts	☐ Weak nails

Head, Eyes, Ears, Nose and Throat

☐ Dizziness	☐ Difficulty swallowing	☐ Migraines	☐ Glasses
☐ Eye strain	☐ Poor vision	☐ Night Blindness	☐ Cataracts
☐ Blurred vision	☐ Earaches	☐ Ringing in ears	☐ Poor hearing
☐ Ringing in ears	☐ Eye floaters	☐ Sinus problems	☐ Nose bleeds
☐ Recurrent sore throats	☐ Grinding teeth	☐ Headaches	☐ Jaw clicks/locks

Cardiovascular

☐ Chest pain or pressure	☐ Irregular heart beat	☐ Palpitations at rest	☐ Fainting
☐ Cold hands/feet	☐ Swelling of hands/feet	☐ Phlebitis	☐ Shortness of breath
☐ Varicose veins	☐ High blood pressure	☐ Low blood pressure	☐ Spontaneous sweating

Respiratory

☐ Cough/Wheezing	☐ Coughing blood	☐ Asthma	☐ Bronchitis
☐ Pneumonia	☐ Pain w/deep inhalation	☐ Production of phlegm-what color?_______________	

Gastrointestinal

☐ Nausea	☐ Diarrhea	☐ Constipation	☐ Black stools
☐ Blood in stool	☐ Indigestions	☐ Rectal pain	☐ Hemorrhoids
☐ Bloating	☐ Chronic laxative use	☐ Acid reflux/GERD	☐ Excessive hunger
☐ Excessive thirst	☐ IBS/Crohn's disease	☐ Poor appetite	

Urinary

☐ Pain on urination	☐ Frequent urination	☐ Blood in urine	☐ Urgent urination
☐ Unable to hold urine	☐ Kidney stones	☐ UTI	☐ Burning urination
☐ Decreased libido	☐ Excessive libido	☐ Night urination-how often?__________	

Women only
Gynecological/Reproductive

- ☐ Painful Intercourse
- ☐ Vaginal dryness
- ☐ Uterine Fibroids
- ☐ Irregular menstruation
- ☐ PMS
- ☐ Ovarian cysts
- ☐ Endometriosis
- ☐ Vaginal discharge
- ☐ Infertility
- ☐ Painful menstruation
- ☐ Age of first menses __________
- ☐ Date of last menses ___________
- ☐ Number of pregnancies ________
- ☐ Number of live births __________
- ☐ Number of miscarriages ________

Do you practice birth control? ________
What type? ______________ How long? ___________

Musculoskeletal

- ☐ Neck pain
- ☐ Carpal Tunnel
- ☐ Foot/ankle pain
- ☐ Muscle weakness
- ☐ Back pain   Low____ Middle____ Upper____
- ☐ Shoulder pain
- ☐ Knee pain
- ☐ Hip pain
- ☐ Tendonitis
- ☐ Hand/wrist pain
- ☐ Sciatica
- ☐ Muscle pain
- ☐ Rotator cuff

Neuropsychological

- ☐ Seizures
- ☐ Lack of coordination
- ☐ Anxiety/Panic attacks
- ☐ Depression
- ☐ ADD/ADHD
- ☐ Loss of balance
- ☐ Poor memory
- ☐ Bad temper/irritable
- ☐ Seasonal Affective Disorder
- ☐ Manic Depression
- ☐ Vertigo/Dizziness
- ☐ Concussion
- ☐ Easily susceptible to stress
- ☐ Nervousness

Have you ever been treated for emotional problems? ☐ Yes ☐ No
Have you ever considered or attempted suicide? ☐ Yes ☐ No
Have you ever been treated for substance abuse? ☐ Yes ☐ No