The Acupuncture Office
Patient Health History Intake DATE___________

NAME:___________________________________ Email ___________________________

Address: __________________________ City/State_______________________ Zip___________

Phone: Home: (_____)___________ Cell:(_____)_____________ Work: (________)______________

Emergency Contact /relationship ________________________________Phone: (____)___________

Date of Birth: ____________ Sex M / F Ht_____ Wt ____ Profession__________________

Marital status: S M D W Health of spouse: Exc /Good/Fair /Poor # of children, if any ____

Name of Child	Age	Sex	Any health concerns?	Name of Child	Age	Sex	Any health concern?
______________	___	M/F	______________	__________	___	M/F	______________
______________	___	M/F	______________	__________	___	M/F	______________

Referred by________________________________ internet phonebook

Overall health (circle one): Excellent / Good / Fair / Poor / Other __________________

Chief Complaints (reason you are here) ____
____

When did it start? ____________________________ Sudden or gradual onset (circle)
If you were given a Western diagnosis, please list ______________________________________
What makes it better?___________________________ What makes it worse?______________

If you've tried other treatments, list and indicate effectiveness
____ ___________________________________
____ ___________________________________

Other current complaints	Current Medications	Vitamins/Supplements
________________________	_____________________	______________________
________________________	_____________________	______________________
________________________	_____________________	______________________
________________________	_____________________	______________________

Surgeries (list with dates) ___________________________ ___________________________
___________________________ ___________________________

Trauma: Falls/injuries/accidents, etc. (list with dates)
________________________________ _______________________________________
________________________________ _______________________________________

List any scars you have from surgeries or cuts:____

Emotional status in general? Happy Depressed Worried Angry Afraid Stressed
Other________________________
My social, family and personal relationships are :
Very Fulfilling Usually Fulfilling Rarely Fulfilling Horrible Indifferent

Family history of serious illness: (circle)
Cancer Diabetes Heart Other: ________________________

Do you have any religion based dietary restrictions? (i.e. Vegetarian, Kosher, etc)___________
Do you have any food allergy or sensitivity based diet restrictions? _______________________
What does your typical diet include? (Please circle all)
Meat fish eggs dairy vegetables fruit breads starches cakes/cookies sweets
How many meals per day? ______________ Snacks? _____________ Any sugar sub?______
Intake per day: Water _______ Coffee________ Soda _________ Diet soda________
If you smoke or drink alcohol or caffeine, please indicate how much.
Cigarettes ______________ Alcohol_________________ Caffeine ______________________
Are you currently using any recreational drugs? (marijuana, etc)________________________

Rest/Activity
How many hours of sleep do you get a night? _____________ (see General Feelings area)
Do you get regular exercise? Yes No Type____________________ Frequency______________
____________________ ______________

Past & Present Condition

___AIDS/HIV ___Diabetes ___High Blood Pressure ___Rheumatic Fever
___Alcoholism ___Emphysema ___Measles ___Scarlet Fever
___Allergies ___Epilepsy ___Multiple Sclerosis ___Seizures
___Appendicitis ___ Goiter ___Mumps ___Stroke
___Arteriosclerosis ___Gout ___ Pacemaker ___Thyroid disorder
___Asthma ___Heart disease ___Pleurisy ___Ulcer
___Cancer ___Hepatitis ___Pneumonia ___Venereal Disease
___Chicken Pox ___Herpes ___Polio ___Whooping cough

General Feelings

___Fatigue ___Recurrent Fever ___Trouble falling asleep ___Swelling
___Cold hands/feet ___Bleed / bruise easily ___Waking at night ____Heavy feeling
___Chills ___Weight gain / loss ___Night sweats
___Hot feeling ___Muscle cramps ___Dream-disturbed sleep
___Sweat easily ___Dizzy / Vertigo ___Numbness / tingling / tremors

Digestion / Appetite

___Nausea ___Gas ___Heartburn ___Anal itch / burning / fissure
___Bloating ___Diarrhea ___Indigestion ___Bowel movements:_________/day
___Vomiting ___Constipation ___Stomach pain ___Stools: soft / hard / black / blood
___Excessive appetite ___No appetite ___Cravings: sweets / salt / carbs

Cardiovascular

___High blood pressure ___Irregular heartbeat ___Fainting ___Phlebitis
___Low blood pressure ___Palpitations ___Chest pain ___Blood clots

Respiratory

___Shortness of breath ___Bronchitis Cough: ___Dry ___Wet ___Coughing blood
___Tightness in chest ___Wheezing Mucus: ___Thin ___Thick

Head ___Eye pain ___Facial pain ___Lip / tongue sores ___Poor hearing
___Red / Itchy eyes ___TMJ ___Excess saliva ___Ringing in ears
___Dry eyes ___Grind teeth ___Sore throat ___Concussion
___Blurred vision ___Gum problem ___Swollen glands ___Lump in throat
___Glaucoma / Cataract ___Dry mouth ___Sinus problem ___Headache / Migraine

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Skin & Hair
___Acne ___Ulcerations ___Itching ___Rash ___Hair loss
___Hives ___Psoriasis ___Eczema ___Fungal infection ____Dandruff

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Emotional
___Phobias ___Irritable ___Work stress ___Seeing a therapist
___Poor memory ___Easily stressed ___Relationship stress ___Physical abuse victim
___Anxiety ___Easily angered ___Family stress ___Sexual abuse victim

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Urinary-Genital
___Painful urination ___Bedwetting ___Urination frequency: _____x day
___Urgent urination ___Unable to hold urine ___ Volume of urine: scant / regular / high
___Incomplete urination ___Blood in urine ___Wake to urinate _______ x night
___Increased libido ___Decreased libido ___Kidney stones

FEMALE ___Uterine Fibroids ___Ovarian cysts
Date last period began: ______ Age menses began_____ Typical # days ____

Menstrual: Flow: heavy / light Color: light red/dark red/ brown
___Painful ___Fatigue ___Headache ___Back pain ___ PMS ___Spotting
Pregnancies:
# of children____ Miscarriages___ Abortions___ Caesarean___ Excess blood loss___
Menopause: Began at what age? _____
___Hot flashes ___Insomnia ___Night sweats ___Mood swings ___Dryness

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MALE
___Prostate problems ___Erectile dysfunction ___Premature ejaculation

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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 (10 is highest)
____
*can also indicate # on diagram

What decreases the pain?
____

What causes the pain to increase?
____

OTHER:
☐ Tingling
☐ Itching
☐ Numbness
☐ Neuropathy
☐ Tension/Tightness
☐ Limited Range of Motion
☐ Limited Use