



**Office use only**

Access \_\_\_\_\_  
AQ \_\_\_\_\_  
QB \_\_\_\_\_

### Confidential patient health history

Name		Date of birth	Sex/Gender	
Address		City	State	Zip
Home phone	Work or mobile phone		Email	
Occupation(s):				
Current employer (if any):				
Primary physician name (if any)		Physician address/phone number		
Emergency contact name	Relationship to you	Day phone	Night phone	
How did you hear about us?		Have you ever had acupuncture before?		
What are your primary concerns for treatment?				
1)				
2)				
3)				
Please list any major illnesses, accidents, or surgeries:				
Please list any medications or supplements you are currently taking:				
Please check any illness that have occurred in blood relatives (check twice if more than one relative has):				
<input type="checkbox"/> <input type="checkbox"/> Diabetes <input type="checkbox"/> <input type="checkbox"/> High blood pressure <input type="checkbox"/> <input type="checkbox"/> Heart disease <input type="checkbox"/> <input type="checkbox"/> Kidney disease <input type="checkbox"/> <input type="checkbox"/> Cancer <input type="checkbox"/> <input type="checkbox"/> Stroke				
How would you characterize your health, in general? Good, fair, poor?				
How was your health as a kid?				
When was your last complete medical exam?		Do you have a good support network (e.g. friends, family, church)?		

Please check any symptoms that you have, or have had in the last year:

<b>General/Energy</b>			
<input type="checkbox"/> fatigue/exhaustion	<input type="checkbox"/> low appetite	<input type="checkbox"/> sweating at night	<input type="checkbox"/> depression
<input type="checkbox"/> restless sleep	<input type="checkbox"/> excessive hunger	<input type="checkbox"/> fever/chills	<input type="checkbox"/> high stress/overwhelm
<input type="checkbox"/> trouble falling asleep	<input type="checkbox"/> strong thirst	<input type="checkbox"/> bleed/bruise easily	<input type="checkbox"/> anger/irritability
<input type="checkbox"/> trouble staying asleep	<input type="checkbox"/> weight loss/gain	<input type="checkbox"/> cold hands/feet	<input type="checkbox"/> sadness/grief
<input type="checkbox"/> anxiety/worry	<input type="checkbox"/> cravings _____	<input type="checkbox"/> dizziness or vertigo	<input type="checkbox"/> mental fog
<b>Digestive system</b>			
<input type="checkbox"/> nausea	<input type="checkbox"/> ulcers	<input type="checkbox"/> diarrhea/loose stool	<input type="checkbox"/> blood/pus in stool
<input type="checkbox"/> vomiting	<input type="checkbox"/> acid reflux	<input type="checkbox"/> constipation/hard stool	<input type="checkbox"/> hemorrhoids
<input type="checkbox"/> belching	<input type="checkbox"/> gas/farting	<input type="checkbox"/> intestinal cramps/pain	<input type="checkbox"/> other _____
<b>Musculoskeletal/Neurological</b>			
<input type="checkbox"/> muscle strain/pull	<input type="checkbox"/> swollen joints	<input type="checkbox"/> weakness/limited use	<input type="checkbox"/> epilepsy
<input type="checkbox"/> joint pain	<input type="checkbox"/> nerve pain	<input type="checkbox"/> limited range of motion	<input type="checkbox"/> tics
<input type="checkbox"/> body aches/heaviness	<input type="checkbox"/> numbness/tingling	<input type="checkbox"/> seizures	<input type="checkbox"/> other _____
<b>Cardiovascular</b>			
<input type="checkbox"/> chest pain	<input type="checkbox"/> high blood pressure	<input type="checkbox"/> rapid/irregular heartbeat	<input type="checkbox"/> swollen ankles
<input type="checkbox"/> hardening of arteries	<input type="checkbox"/> low blood pressure	<input type="checkbox"/> previous heart attack	<input type="checkbox"/> blood clots
<input type="checkbox"/> poor circulation	<input type="checkbox"/> fainting		<input type="checkbox"/> other _____
<b>Head/Eyes/Ears/Nose/Throat/Respiratory</b>			
<input type="checkbox"/> headaches	<input type="checkbox"/> swollen glands	<input type="checkbox"/> difficulty breathing	<input type="checkbox"/> gum problems
<input type="checkbox"/> migraines	<input type="checkbox"/> frequent colds	<input type="checkbox"/> persistent cough	<input type="checkbox"/> tooth problems
<input type="checkbox"/> earaches/infections	<input type="checkbox"/> allergies/hay fever	<input type="checkbox"/> coughing	<input type="checkbox"/> tongue sores
<input type="checkbox"/> ear ringing	<input type="checkbox"/> sinus problems	<input type="checkbox"/> blood/phlegm	<input type="checkbox"/> eye pain/strain
<input type="checkbox"/> loss of hearing	<input type="checkbox"/> chronic sore throat	<input type="checkbox"/> wheezing/asthma	<input type="checkbox"/> other _____
<b>Skin and Hair</b>			
<input type="checkbox"/> rashes	<input type="checkbox"/> psoriasis	<input type="checkbox"/> dry skin	<input type="checkbox"/> fungal infections
<input type="checkbox"/> hives	<input type="checkbox"/> acne	<input type="checkbox"/> itchiness	<input type="checkbox"/> non-healing sores
<input type="checkbox"/> eczema	<input type="checkbox"/> warts	<input type="checkbox"/> hair loss	<input type="checkbox"/> other _____
<b>Genito-Urinary</b>			
<input type="checkbox"/> difficult urination	<input type="checkbox"/> painful urination	<input type="checkbox"/> kidney infection/stones	<input type="checkbox"/> lowered libido
<input type="checkbox"/> frequent urination	<input type="checkbox"/> blood/pus in urine	<input type="checkbox"/> urine incontinence	<input type="checkbox"/> edema/water retention
<b>Male</b>	<b>Female</b>		
<input type="checkbox"/> prostate trouble	<input type="checkbox"/> painful periods	<input type="checkbox"/> breast problems (lumps, mastitis,?) _____	
<input type="checkbox"/> erection difficulties	<input type="checkbox"/> irregular periods	<input type="checkbox"/> abortion	<input type="checkbox"/> miscarriage
<input type="checkbox"/> penis discharge	<input type="checkbox"/> heavy flow/spotting	<input type="checkbox"/> given birth	<input type="checkbox"/> menopause
<input type="checkbox"/> other _____	<input type="checkbox"/> PMS	<b>Any chance you are pregnant? Yes/No</b>	
<b>Gender Identity</b>			
Do you identify as Male Female, Transgendered, or other (please specify)? _____		Which pronoun do you prefer: M/F	

The information on this form is correct to the best of my knowledge.

Name \_\_\_\_\_

Date \_\_\_\_\_