Confidential Health History

Name_____ Date_____ Height_____ Weight_____

Preferred contact phone#_____ other phone_____

Email address_____

Mailing address_____
street city State zip

Age_____ Date of Birth_____ Occupation_____

Contact in case of emergency _____ Relationship_____

Referred by_____ Have you had acupuncture before?_____

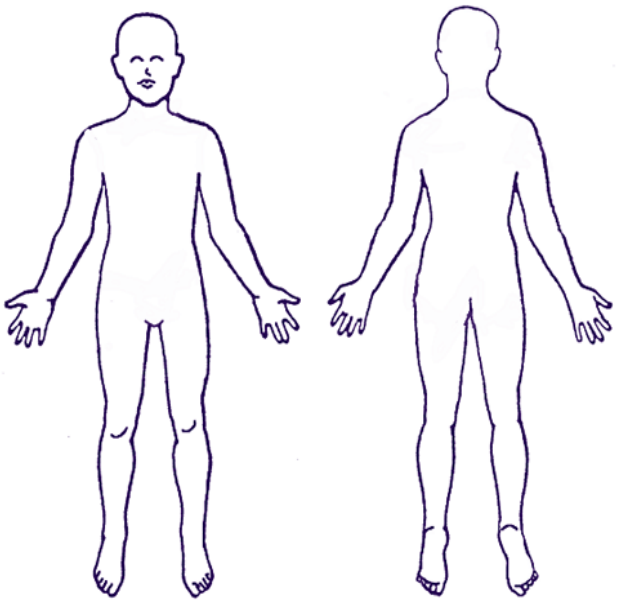
Primary care physician_____

Please list reason for you appointment today from most to least important.

1._____ _____How long?_____

2._____ _____How long?_____

Please indicate problem areas:



Other types of treatment you have tried:_____

List any medications, herbs, or supplements taken on a regular basis:_____

_____

Surgeries or significant trauma (auto accidents, falls, etc. Please list type and date):

_____

Please describe your typical daily diet:

Breakfast_____

Lunch_____

Dinner_____

Snacks_____

Allergies, food sensitivities, or dietary restrictions: _____

_____

___# of caffeinated beverages daily __# of alcoholic beverages per week

___# of glasses of water per day Do you use tobacco? Yes/no

Do you have a pacemaker? Yes/No Do you have a bleeding disorder? Yes/No

Describe relaxation activities_____

_____

Additional information

_____

Does your health history include any of the following:

__diabetes __thyroid disorder __blood clots __ seizures __hepatitis

__cancer
date/type_____

Please check any of the following that you have experienced in the past 3 months:

Temperature
__often feel warm
__often feel cold
__cold feet and hands
__sweating easily without exertion
__rarely sweat
__night sweats

Digestive
__appetite low/high
__gas
__bloating
__stomach pain
__nausea
__diarrhea
__constipation
__loose stool
__undigested food in stool
__acid reflux

Sleep
__# of hours per night
__longer than 30 min to fall asleep
__apnea

Urinary
__frequent urination
__getting up at night to urinate
__painful urination
__recurrent infections

Eyes
__spots in visual field
__blurry vision
__dry eyes

Head/Ears/Nose/Throat
__headaches
__dizziness
__ear ringin
__hearing loss
__sinus problems
__chronic colds/flu
__hayfever/allergies
__chronic sore throats

Cognitive/Emotional
__anxiety
__depression
__excessive stress
__poor memory
__other_____

Heart/Chest
__chest pain
__heart palpitations
__fluttering in chest
__trouble breathing deeply
__shortness of breath
__heart disease
__hypertension
__poor circulation
__high cholesterol
__history of stroke
__asthma

Skin/Hair
__cold sores
__mouth sores
__dry skin/hair
__other_____

For Women Only:
_irregular menstruation
__# of days in cycle
__# of bleeding days
__post-menopausal
__age of first menses
__painful menstruation
__PMS
__headaches with cycle
*other*_____
__# of pregnancies
_____ages of children

Energy
__sufficient daily energy
_morning fatigue
_fatigue after eating
__general fatigue

Neuro/Mus/Skeletal
__chronic pain
Explain_____
__ numbness/tingling
__muscle cramps
__paralysis
__weakness in limbs
__swelling/edema

My health and medical information represented here is true and correct to the best of my knowledge

Patent signature Date