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Acupuncture Health History Intake

Date: _____

Name _____

Sex M F Birthdate _____ Age _____

Address _____

City/State/Zip Code _____

Home Phone _____ Work Phone _____ Cell Phone _____

Is it ok to leave a message on an answering machine? _____

Email Address _____ Is it ok to contact you via email? Y/N

Emergency Contact Name _____ Phone _____

Who should we thank for referring you to our office? _____

I will be paying for my appointments by: Cash/Credit Flex Card Insurance

If using Insurance, what is the name of your carrier? _____

My co-pay amount is: _____ ID# _____ Group _____

Please list your major health concerns that you would like addressed today in order of priority:

1. _____
2. _____
3. _____
4. _____
5. _____

Have you received acupuncture therapy before? _____ When? _____

With whom? _____

Please List any Medications or Supplements you are currently taking:

Are you currently under the care of other practitioners? Y N

If so, with whom? _____

For what conditions? _____

What other forms of treatment have you sought? _____

Has it helped at all? _____

Please list any allergies or sensitivities _____

List any hospitalizations, surgeries or accidents _____

Approximate Date _____

Please list any labs or test results _____

Height _____ Weight _____ Are you satisfied with your weight? Y N

Please indicate any significant illnesses you or a blood relative have or have had:

Illness	You	Relative	Approx. Date
Cancer	_____	_____	_____
Hepatitis	_____	_____	_____
Hypertension	_____	_____	_____
Rheumatic Fever	_____	_____	_____
Diabetes	_____	_____	_____
Heart Disease	_____	_____	_____
Seizures	_____	_____	_____
Emotional D/O	_____	_____	_____
Tuberculosis	_____	_____	_____
Gonorrhea	_____	_____	_____
Syphillis	_____	_____	_____
HIV/Aids	_____	_____	_____
HPV	_____	_____	_____
Herpes	_____	_____	_____

Please indicate the use and frequency of the following:

	Yes	No	How often?		Yes	No	How often?
Coffee	_____	_____	_____	Tobacco	_____	_____	_____
Alcohol	_____	_____	_____	Soda pop	_____	_____	_____
Recreational	_____	_____	_____	Water	_____	_____	_____
Drugs	_____	_____	_____	Intake	_____	_____	_____

For Men:

Date of last prostate check up _____ PSA results _____ Lab Results _____

Manual Prostate Exam Results _____

Freq. Of urination: Daytime _____ Nighttime _____ Color of urine _____

Is there a strong odor? Y N

Circle any prostrate symptoms you are experiencing:

Rectal dysfunction Back pain Groin pain Delayed stream Dribbling

Incontinence Retention of Urine Increased libido Decreased Libido

Impotence Premature Ejaculation Testicular pain Other _____

For Women:

Are you pregnant? Y N Age of 1st period _____ Age of last period _____

of pregnancies _____ # of live births _____ # of abortions _____

of miscarriages _____ # of days between periods _____ # of days of flow _____

Color of flow _____ Clots Y N Flow is: Light Medium Heavy

Date of last: Pap Smear _____ Mammogram _____ Bone Density Scan _____

Results: _____

Circle any of the following conditions you have received as a diagnosis:

Fibroids Fibrocystic Breasts Ovarian Cysts PID Endometriosis

Circle symptoms you experience related to your menstrual cycle:

Discharge	Vaginal Dryness	Headaches	Nausea
Constipation	Diarrhea	Swollen Breasts	Tender Breasts
Mood Swings	Ravenous Appetite	Poor Appetite	Hot Flashes
Night Sweats	Increased Libido	Decreased Libido	Insomnia
Bloating	Cramping	Bearing Down Sensation	

Symptom Survey For Everyone:

The following is a list of symptoms that you may or may not ever experience. Please indicate a check mark next to the symptoms you sometimes experience and a + sign by the symptoms you experience frequently.

Earth:

lack of appetite excessive appetite loose stool or diarrhea vomiting
 nausea indigestion belching/burping heartburn/reflux
 feeling of food retention in the stomach tendency to obsession in work/relationships

Fire:

insomnia heart palpitations cold hands & feet nightmares mental restlessness
 angina pain chest pain abdominal pain sciatic pain headaches
 pain or coldness in genitals laughing for no reason

Metal:

cough grief decreased sense of smell nasal problems
 skin problems bronchitis diverticulitis colitis
 claustrophobia anxiety recent antibiotic use hemorrhoids
 constipation shortness of breath

Water:

low back pain knee problems ear ringing hearing loss kidney stones
 hair loss decreased sex drive urinary problems incontinence
 early morning diarrhea

Wood:

eye problems jaundice gall stones soft nails
 brittle nails light colored stools easily angered spasms or twitching
 high blood pressure high cholesterol sighing hiccups
 difficulty making decisions difficulty digesting oily foods

Blood and Qi:

fatigue edema blood in stool black tarry stool easily bruised
 allergies hay fever frequent colds dizziness sudden weight loss
 dry skin dry hair hair falling out poor memory
 intolerance to weather changes