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HEALTH HISTORY FORM

Please complete this form to provide your practitioner with thorough health history information.

Print legibly and mark any areas of confusion with a question mark.
All information recorded on this form is completely confidential.

NAME _____ Today's Date ___ / ___ / _____
First Middle Last

ADDRESS _____ CITY _____

STATE _____ ZIP CODE _____ E-MAIL _____

CELL PHONE _____ HOME / WORK PHONE _____

May we contact you via email ? Y / N Which phone number may we call? _____
May we contact you by phone? Y / N May we leave voicemail messages? Y / N

DATE OF BIRTH ____ / ____ / _____ AGE _____ GENDER _____

MARITAL STATUS _____ HEIGHT _____ WEIGHT _____

CURRENT OCCUPATION _____ HOURS of WORK per WEEK _____

Do you enjoy your work? Y / N Why or why not? _____

Do you have a primary care physician? Y / N Doctor Name: _____

Primary Care Office / Medical Group: _____

EMERGENCY CONTACT INFORMATION:

Name _____ Relationship _____ Phone Number _____

How did you hear about our practice? _____

Have you visited our website / social media pages? Y / N

Have you received acupuncture treatment before? Y / N

If so, when and with whom? _____

Please inform us about your current health concerns in order of importance...

CONDITION A

_____

Condition Name / Description

_____

Past Treatment(s) Received

_____

When did this condition begin?

_____

How does this condition affect you and your quality of life?

Please rate the current severity of Condition A by marking an "X" on the line below:

No Problem |_____| Worst Imaginable

CONDITION B

_____

Condition Name / Description

_____

Past Treatment(s) Received

_____

When did this condition begin?

_____

How does this condition affect you and your quality of life?

Please rate the current severity of Condition B by marking an "X" on the line below:

No Problem |_____| Worst Imaginable

PLEASE LIST ANY ADDITIONAL CONCERNS HERE:

List any allergies/sensitivities to food, medications, drugs, or environmental factors, including your reaction:

_____

_____

_____

Please list all medications you are currently taking, including prescribed drugs, over-the-counter medications, vitamins, dietary supplements, and herbal supplements. **You may attach a separate sheet of current medications to this packet.**

Medication	Dosage	Condition	For how long?	Prescribed by...

Please indicate if you are taking any of the following medications:

- ❑ Blood thinners (warfarin, Coumadin, etc.)
- ❑ Pain relievers (aspirin, Tylenol, etc.)
- ❑ Cortisone (and other steroids)
- ❑ Sedatives/tranquilizers
- ❑ Thyroid medications
- ❑ Diet pills/diet teas
- ❑ Sleep aids
- ❑ Laxatives
- ❑ Antacids / omeprazole

Please indicate if any of the following conditions* pertain to your health history:

- ❑ Hepatitis (A, B, C)
- ❑ Bleeding disorder
- ❑ Currently pregnant
- ❑ High blood pressure
- ❑ Neuropathy
- ❑ Potentially pregnant
- ❑ Diabetes
- ❑ Needle phobia
- ❑ Pacemaker
- ❑ Multiple Sclerosis
- ❑ Seizures/epilepsy
- ❑ History of cancer

*These conditions do not make you ineligible for treatment, but may limit treatment modalities utilized by your practitioner.

Have you had any courses of antibiotics recently? Y / N If yes, how many rounds? _____

Please indicate if you have had any of the following illnesses:

- ❑ Chicken Pox
- ❑ Diphtheria
- ❑ German Measles
- ❑ Measles
- ❑ Shingles
- ❑ Mumps
- ❑ Tuberculosis
- ❑ Rheumatic Fever
- ❑ Scarlet Fever
- ❑ C-Diff

Please indicate if you have any of the following sexually transmitted infections in your history:

- ❑ Chlamydia
- ❑ Gonorrhea
- ❑ Herpes
- ❑ HIV
- ❑ HPV
- ❑ Syphilis

Please list any hospitalizations, physical trauma, or surgical procedures in your health history:

Reason or Procedure	Date

Please identify which of the following symptoms you experience:

Record an "O" for symptoms you experience occasionally. Record an "F" for symptoms you experience frequently.

___ Belching/burping
___ Bloating
___ Edema
___ Bloody stools
___ Diarrhea/loose stools
___ Cravings for sweets
___ Easy bruising/bleeding
___ Excessive appetite
___ Quickly feeling full
___ "Stuck" feeling in stomach
___ Lack of appetite
___ Heartburn/acid reflux
___ Heaviness in limbs
___ Foggy brain
___ Mucus/phlegm in stool
___ Overthinking
___ Nausea
___ Tarry stools
___ Weight gain tendencies
___ Tiredness after meals
___ Vomiting

___ Angina/chest pain
___ Easily startled
___ Nightmares/vivid dreams
___ Insomnia/trouble sleeping
___ Lack of joy in life
___ Heart palpitations
___ Mental restlessness
___ Hot sensation in chest
___ Laughing for no reason

___ Acne
___ Allergies
___ Asthma
___ Bronchitis
___ Colitis/diverticulitis
___ Cough
___ Coughing up phlegm
___ Dry mouth/nose/throat
___ Frequent colds/flu viruses
___ Grief/sadness
___ Hemorrhoids
___ Hives
___ IBS/Crohn's disease
___ Nasal discharge
___ Post nasal drip
___ Red, painful throat
___ Shortness of breath
___ Skin rashes
___ Sneezing
___ Snoring

___ Blurred vision/floaters
___ Jaw clenching
___ Grinding teeth at night
___ Difficulty making decisions
___ Jaundice
___ Gallstones
___ Easily angered/irritable
___ Difficulty digesting oily foods
___ Lightly colored stools
___ Neck/shoulder tension
___ Skin rashes
___ Spasms/muscle twitches

___ Craving salty food
___ Dry hair or skin
___ Excessive sex drive
___ Low sex drive
___ Feeling cold easily
___ Ear ringing/tinnitus
___ Hair loss
___ Hearing impairment
___ Knee pain
___ Kidney stones
___ Feeling lump in the throat
___ Hot flashes
___ Night sweats
___ Nighttime urination
___ Soft/brittle nails
___ Urinary problems
___ Low back pain
___ Poor memory/forgetful

Please indicate which of these conditions (to your knowledge) apply to you & your immediate family members:

	Yourself	Father	Mother	Brother(s)	Sister(s)
Arthritis	_____	_____	_____	_____	_____
Asthma	_____	_____	_____	_____	_____
Cancer	_____	_____	_____	_____	_____
Diabetes	_____	_____	_____	_____	_____
Hay Fever/Hives	_____	_____	_____	_____	_____
Heart Disease	_____	_____	_____	_____	_____
Hepatitis	_____	_____	_____	_____	_____
High Blood Pressure	_____	_____	_____	_____	_____
Kidney Disease	_____	_____	_____	_____	_____
Mental Illness	_____	_____	_____	_____	_____
Seizures/Epilepsy	_____	_____	_____	_____	_____
Stroke	_____	_____	_____	_____	_____
Substance abuse	_____	_____	_____	_____	_____
Tuberculosis	_____	_____	_____	_____	_____
Thyroid Disease	_____	_____	_____	_____	_____

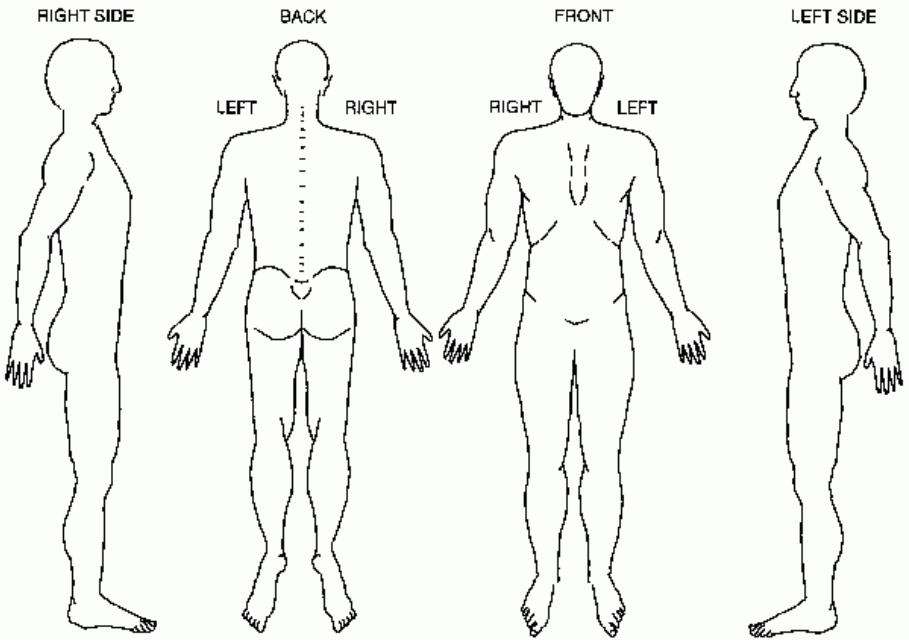
Please indicate any musculoskeletal discomfort/dysfunction you have experienced:

- ❑ Osteoporosis
- ❑ Wrist/hand pain
- ❑ Sciatica
- ❑ ACL tear
- ❑ Carpal tunnel syndrome
- ❑ Limited range of motion
- ❑ Rotator Cuff problems
- ❑ Osteoarthritis
- ❑ Hammer toe
- ❑ Shin splints
- ❑ Trigger finger
- ❑ Stress fracture
- ❑ Sprain/strain
- ❑ Meniscus tear
- ❑ Rheumatoid arthritis
- ❑ General muscle pain
- ❑ Shoulder pain
- ❑ Muscle weakness
- ❑ Neuropathy
- ❑ Tendonitis
- ❑ Adhesive capsulitis
- ❑ Back pain
- ❑ Foot pain
- ❑ Hip pain
- ❑ Knee pain
- ❑ Ankle pain
- ❑ Neck pain

Please mark any area(s) of injury, pain, or discomfort on the chart.

Indicate severity with a number from 1 (mild) to 10 (excruciating) and indicate the quality with the following symbols:

AAA: aching
BBB: burning
NNN: numbness
PPP: pins & needles
SSS: stabbing



DIET & LIFESTYLE

How many meals do you eat per day? _____ Do you snack during the day? Y / N If yes, at what times? _____

What types of meals do you typically eat?

Breakfast: _____ Lunch: _____

Dinner: _____ Snacks: _____

Please list daily intake of the following beverages:

Water _____ Tea _____ Coffee _____ Energy Drinks _____ Soda _____ Juice _____

Please indicate your past or present use of the following substances (if applicable):

Caffeine: _____ Alcohol: _____

Nicotine: _____ Recreational drugs: _____

Do you exercise throughout the week? Y / N What types of exercise are a part of your routine? _____

Is physical activity a part of your occupation (do you have a physically strenuous job)? Y / N

Please rate your overall stress level: ❑ Low ❑ Medium ❑ High

What would you identify as your primary source(s) of stress? _____

Average amount of hours of sleep per night: _____ Do you wake feeling rested? Y / N

Do you have problems falling or staying asleep? Y / N

If yes, please describe: _____

Do you frequently donate blood or plasma? Y / N If yes, how often? _____

We create a safe, trauma-informed space for healing.

Have you experienced any major traumas such as abuse, child loss, sexual violence, accidents, physical trauma, PTSD, difficult loss of a loved one, etc.? Y / N

If yes, please describe to the level of your comfort: _____

_____

WOMEN'S HEALTH

Do you currently menstruate? Y / N Date of last period: _____

Date of last OB/GYN examination: _____ At what age did you begin menstruating? _____

Are you currently sexually active? Y / N History of STDs? _____

What form(s) of birth control do you utilize? _____

What form(s) of birth control have you utilized in the past? _____

Have you utilized fertility treatments in the past? If so, what type? _____

Do you experience any sexual difficulties? If yes, please describe to your level of comfort: _____

_____

Are you currently pregnant? Y / N Are you trying to become pregnant? Y / N

No. of live births: _____ No. of terminations: _____ No. of miscarriages: _____ Total No. of pregnancies: _____

Birth Number	Year	Length (Weeks)	Hours of Labor	Delivery Type	Baby's Sex	Baby's Weight	Any Complications?
#1							
#2							
#3							
#4							
#5							

Do you have history of any of the following conditions?

- ❑ Endometriosis
- ❑ Yeast Infections
- ❑ Genital Lesions
- ❑ Fibrocystic Breast
- ❑ Hysterectomy
- ❑ Uterine Fibroids
- ❑ Itchy Genitalia
- ❑ Breast Cancer
- ❑ Nipple Discharge
- ❑ Uterine Prolapse
- ❑ Abnormal Pap Smear
- ❑ Urinary Tract Infections
- ❑ Pelvic Inflammatory Disease
- ❑ Polycystic Ovaries (PCOS)
- ❑ Pelvic Floor Dysfunction
- ❑ Ovarian Cyst
- ❑ Vaginal Pain
- ❑ Vaginal Odor
- ❑ Severe Vaginal Discharge
- ❑ Cervical Cancer

For women currently menstruating …

No. of days between periods: _____ No. of days you bleed per period: _____ Spotting between periods? Y / N

Is your bleeding: ❑ Heavy ❑ Moderate ❑ Light ❑ Minimal

Have your periods changed since you began menstruating? Y / N
Please describe any changes: _____

What color in your menstrual blood? (check all colors that apply)
❑ Pale Red/Pink ❑ Red ❑ Bright Red ❑ Dark Red ❑ Dark Red/Brown ❑ Very Dark

What form(s) of menstrual products do you use? (check all products that apply)
❑ Pad ❑ Panty Liners ❑ Tampons ❑ Menstrual Cup ❑ Period Underwear

How many pads/tampons do you use each day of your period?
Day 1: ___ Day 2: ___ Day 3: ___ Day 4: ___ Day 5: ___ Day 6+: ____

On your heaviest day, which absorbency pad/tampon do you use?
❑ Light ❑ Regular ❑ Super ❑ Super Plus

On average, how often do you change your pad/tampon?
❑ Every hour (or less) ❑ Every 2 hours ❑ Every 4 hours ❑ Every 5+ Hours

Do you experience pain around your period? Y / N ❑ Before ❑ During ❑ After
Rate the severity of the pain: ❑ Mild ❑ Moderate ❑ Severe

Where do you experience menstrual pain? _____

Identify the quality of the pain: ❑ Cramping ❑ Stabbing ❑ Aching ❑ Dull ❑ Comes & Goes ❑ Constant

Do you pass clots? Y / N What color are the clots? ❑ Bright Red ❑ Dark Red ❑ Brownish ❑ Dark Purple ❑ Black ❑ Mucus

How large are the clots? ❑ Small and stringy ❑ Small and spotty ❑ Size of a dime ❑ Size of a quarter ❑ Size of egg yolk ❑ Size of your fist

Do you have pain with the passing of your clots? Y / N Do you feel better after passing clots? Y / N

Do you experience the following symptoms?

Mark "B" for before your period. Mark "D" for during your period. Mark "A" for after your period.

___ Bloating	___ Discharge	___ Insomnia	___ Low Appetite	___ Spotting
___ Constipation	___ Salty Cravings	___ Sweet Cravings	___ Strong Appetite	___ Headache
___ Low Libido	___ Hot Flashes	___ Nausea	___ Swollen Breasts	___ Diarrhea
___ High Libido	___ Mood Swings	___ Night Sweats	___ Vaginal Dryness	___ Constipation

Do you know what day of your cycle you ovulate? Y / N If yes, which day? _____

Do you use an ovulation prediction kit to determine ovulation? Y / N

Do you chart your Basal Body Temperature (BBT)? Y / N

Do you experience any of the following symptoms at ovulation:

❑ Tender Breasts ❑ Sharp Pain ❑ Cramping ❑ Changes to Bowel Movements ❑ Irritability

Do you notice cervical mucus during ovulation? Y / N If yes, for how many days? _____

Mark the descriptors that apply to your cervical mucus below:

❑ Scant ❑ Moderate ❑ Profuse ❑ Creamy, Thick ❑ Rubbery, Egg Yolk-Like ❑ Watery

Do you experience mucus/discharge at other times during your cycle? Y / N

If yes, describe frequency/quality: _____

MEN'S HEALTH

Date of Last Prostate Check: _____ PSA Result: _____

History of prostate cancer? Y / N If yes, when? _____

Treatment received: _____

History of male factor infertility? Y / N If yes, when? _____

Treatment received: _____

Frequency of urination (list number of times) Daytime: _____ Nighttime: _____

Urine Quality: ❑ Clear ❑ Cloudy ❑ Strong odor ❑ Dark color

Please indicate if you experience any of the following symptoms regarding your genital / urinary health:

❑ Back pain	❑ Discharge/sores	❑ Lumps/masses near the testicles
❑ Bloody urine	❑ Dribbling after urination	❑ Kidney/urinary stones
❑ Rectal dysfunction	❑ Burning urination	❑ Groin pain
❑ Nocturnal emission	❑ Retention of urine	❑ Copious urination
❑ Impotence	❑ Testicular pain	❑ Scanty urination/weak flow
❑ Decreased libido	❑ Increased libido	❑ Painful urination
❑ Urgent urination	❑ Delayed stream	❑ Daytime urinary incontinence
❑ Premature ejaculation	❑ Urinary tract infection	❑ Nighttime urinary incontinence

Are you sexually active? Y / N

Have you fathered any children? Y / N If yes, how many children do you have? _____

Do you have a history of any Sexually Transmitted Infections (STIs)? Y / N

If yes, please describe to the level of your comfort:

_____