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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 leave voicemail messages? Y / N May we send text messages? Y / N

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

MARITAL STATUS _____ HEIGHT _____ WEIGHT _____

DOMINANT HAND: Right Left Ambidextrous

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:

- | | | |
|--------------------------------------------------------------------|--------------------------------------------------|------------------------------------------------|
| <input type="checkbox"/> Blood thinners (warfarin, Coumadin, etc.) | <input type="checkbox"/> Sedatives/tranquilizers | <input type="checkbox"/> Sleep aids |
| <input type="checkbox"/> Pain relievers (aspirin, Tylenol, etc.) | <input type="checkbox"/> Thyroid medications | <input type="checkbox"/> Laxatives |
| <input type="checkbox"/> Cortisone (and other steroids) | <input type="checkbox"/> Diet pills/diet teas | <input type="checkbox"/> Antacids / omeprazole |

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

- | | | | |
|----------------------------------------------|-----------------------------------------------|----------------------------------------|---------------------------------------------|
| <input type="checkbox"/> Hepatitis (A, B, C) | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Multiple Sclerosis |
| <input type="checkbox"/> Bleeding disorder | <input type="checkbox"/> Neuropathy | <input type="checkbox"/> Needle phobia | <input type="checkbox"/> Seizures/epilepsy |
| <input type="checkbox"/> Currently pregnant | <input type="checkbox"/> Potentially pregnant | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> 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:

- | | | | | |
|--------------------------------------|---------------------------------------|------------------------------------------|----------------------------------------|-----------------------------------|
| <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Diphtheria | <input type="checkbox"/> German Measles | <input type="checkbox"/> Measles | <input type="checkbox"/> Shingles |
| <input type="checkbox"/> Mumps | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Scarlet Fever | <input type="checkbox"/> C-Diff |

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

- | | | | | | |
|------------------------------------|------------------------------------|---------------------------------|------------------------------|------------------------------|-----------------------------------|
| <input type="checkbox"/> Chlamydia | <input type="checkbox"/> Gonorrhea | <input type="checkbox"/> Herpes | <input type="checkbox"/> HIV | <input type="checkbox"/> HPV | <input type="checkbox"/> 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.

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

- | | | |
|--------------------------------------------------|----------------------------------------------------|-------------------------------------------------|
| <input type="checkbox"/> Angina/chest pain | <input type="checkbox"/> Insomnia/trouble sleeping | <input type="checkbox"/> Mental restlessness |
| <input type="checkbox"/> Easily startled | <input type="checkbox"/> Lack of joy in life | <input type="checkbox"/> Hot sensation in chest |
| <input type="checkbox"/> Nightmares/vivid dreams | <input type="checkbox"/> Heart palpitations | <input type="checkbox"/> Laughing for no reason |

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

- | | | |
|------------------------------------------------------|----------------------------------------------------------|-------------------------------------------------|
| <input type="checkbox"/> Blurred vision/floaters | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Lightly colored stools |
| <input type="checkbox"/> Jaw clenching | <input type="checkbox"/> Gallstones | <input type="checkbox"/> Neck/shoulder tension |
| <input type="checkbox"/> Grinding teeth at night | <input type="checkbox"/> Easily angered/irritable | <input type="checkbox"/> Skin rashes |
| <input type="checkbox"/> Difficulty making decisions | <input type="checkbox"/> Difficulty digesting oily foods | <input type="checkbox"/> Spasms/muscle twitches |

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

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

Unknown Family History / Adopted

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

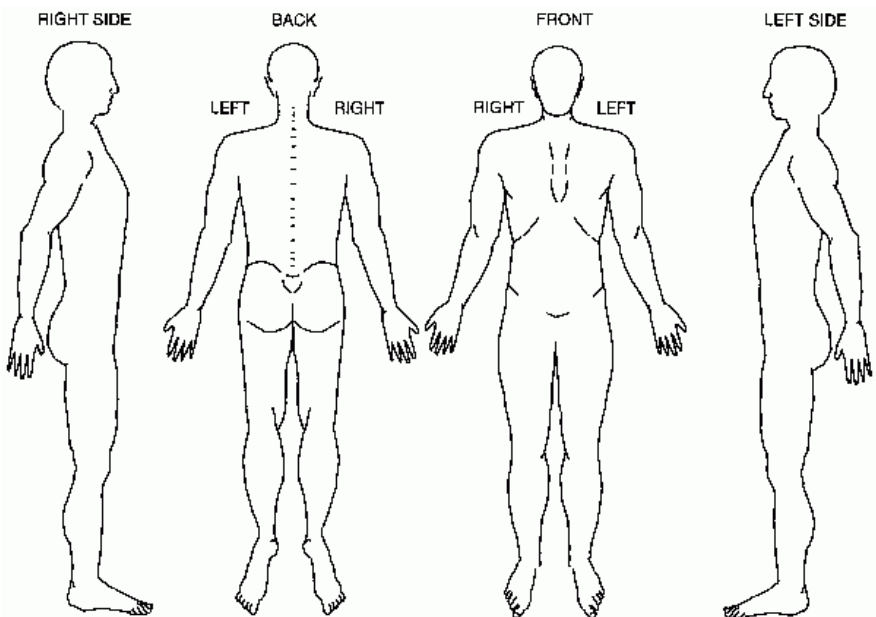
Please indicate any musculoskeletal discomfort/dysfunction you have experienced:

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

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							

No. of living children _____ No. of deceased children _____ Do you have step-children? _____

Do you have adopted children? _____ Do you have children you placed up for adoption? _____

Do you have history of any of the following conditions?

- | | | | |
|---------------------------------------------|-------------------------------------------|------------------------------------------------------|---------------------------------------------------|
| <input type="checkbox"/> Endometriosis | <input type="checkbox"/> Uterine Fibroids | <input type="checkbox"/> Abnormal Pap Smear | <input type="checkbox"/> Ovarian Cyst |
| <input type="checkbox"/> Yeast Infections | <input type="checkbox"/> Itchy Genitalia | <input type="checkbox"/> Urinary Tract Infections | <input type="checkbox"/> Vaginal Pain |
| <input type="checkbox"/> Genital Lesions | <input type="checkbox"/> Breast Cancer | <input type="checkbox"/> Pelvic Inflammatory Disease | <input type="checkbox"/> Vaginal Odor |
| <input type="checkbox"/> Fibrocystic Breast | <input type="checkbox"/> Nipple Discharge | <input type="checkbox"/> Polycystic Ovaries (PCOS) | <input type="checkbox"/> Severe Vaginal Discharge |
| <input type="checkbox"/> Hysterectomy | <input type="checkbox"/> Uterine Prolapse | <input type="checkbox"/> Pelvic Floor Dysfunction | <input type="checkbox"/> 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 biological children do you have? _____

Have you have any adopted / fostered / non-biological / step-children? Y / N

If yes, how many 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:
