Patient History Form

Thank you for considering Acupuncture! On your first visit, we will need you to complete all 4 pages, sign and date them and bring them with you to your appointment.

Name: ______________________ Phone: ______________ Date: __________

Address: ______________________ City: __________ State: __________ ZIP: __________

Ht: __________ WT: __________ Age: __________ Date of Birth: ______________ Marital Status: __________

Home phone: ______________________ Work/Cell phone: ______________________

Email address (optional): ____

Occupation: ______________ Employer: ______________________ Phone: __________

Emergency contact's name and phone: ______________________________________

Family Physician's name and phone: ______________________________________

TREATMENT GOALS:

What is the main condition you would like to address? ______________________

____

Does this affect sleep, work. other? ______________________________________

How long have you had this condition? ____________________________________

What diagnosis, if any, have you been given? ______________________________

What treatments have you tried (list physician, date, results)? ________________

Would you consider taking a herb formula? ________________________________

HEALTH HISTORY:

Current medications (list): ____

Are you taking blood thinners? ____

Are you/might you be currently pregnant? _________________________________

Do you have any implants/pacemaker? ____________________________________

Are you allergic to sulfur? ____

PAST MEDICAL HISTORY:(check all that apply)

_____ Allergies _____ Hepatitis _____ Seizures _____ Cancer
_____ Diabetes _____ Heart Disease _____ Surgery _____ HIV
_____ Stroke _____ High Blood Pressure _____ Epilepsy
_____ Thyroid Disease

Other: ______________________________________

Surgery History: ______________________________________

List previous accidents/injuries/major illnesses: ______________________________________

____

LIFESTYLE: (circle yes or no)

Do you exercise regularly? Y / N ______________________________________

Do you smoke? Y / N If yes, how much? ____________

Do you drink alcohol? Y / N If yes, how much? ____________

How much coffee/tea/soda do you drink per day? ______________________

How much water do you drink per day? ______________________

How often do you eat the following:

vegetables _____ candy _____ dairy _____ red meat _____ chips ________
fruit _____ fast food _____ refined carbs (bread, pastries...)_____

Supplements:______________________________________

____

Check All That Apply:

Energy level:
_____ low energy _____ low energy after exercise _____ lethargic
_____ SOB _____ sleepy during the day _____ reluctant to talk
_____ fatigue _____ catch colds easily

Circulation/blood:
_____ dizziness _____ bleeding _____ nose bleeds _____ floater/spots
_____ numbness/tingling in extremities

Lung & Associated TCM functions

_____ cough _____ dry _____ sputum _____ fever & chills
_____ nose bleeds _____ dry mouth _____ dry skin _____ dry throat
_____ sinus congestion _____ dry nose _____ sneezing _____ overall achy body
_____ sore throat _____ feeling sad _____ allergies _____ difficulty breathing
_____ smoke cigarettes _____ melancholy
_____ headaches: how often? ____________________________

Spleen & Associated TCM functions

_____ low appetite _____ abdominal gas _____ abdominal bloating _____ bruise easily
_____ crave sweets _____ hemorrhoids _____ gurgling stomach _____ nose bleeds
_____ worry _____ over thinking _____ pensive _____ loose stools
_____ urgent BMs _____ diarrhea _____ constipated _____ weight gain
_____ discomfort after BM _____ blood in stool _____ mucus in stool
_____ feel tired after eating _____ undigested food in stool

Number of bowel movements per day ____

_____ Prolapsed organ. If so, which organ and when _____________________________________

Dampness:
_____ general feeling of heaviness in body _____ mental fogginess _____ mental sluggishness
_____ nausea _____chest congestion _____ vaginal discharge _____ overweight
_____ swelling. If so, where:_____________________________________

Stomach & Associated TCM Functions:

_____ heart burn _____ mouth sores _____ pain after eating _____ large appetite
_____ bleeding, painful or swollen gums _____ facial swelling/pain _____ vomiting
_____ bad breath _____ acne _____ acid regurgitation _____ belching
_____ hiccups _____ stomach pain

Liver/Gallbladder & Associated TCM Functions:

_____ alternating diarrhea and constipation _____ high stress level _____ bitter taste in mouth
_____ bad temper _____ headaches _____ anger easily _____ irritable
_____ heat in head/face _____ muscle tension _____ frustration
_____ lump in throat _____ muscle twitches _____ depression _____ feel tense
_____ gall stones _____ itchy skin/rashes _____ high pitch ringing in ears
_____ itch/pain in genitals _____ seizure/convulsions

_____discomfort/tightness/tension around ribcage
_____ sexually transmitted disease____

Eyes:
_____ itchy _____ blood shot _____ dry _____ watery _____ blurred vision
_____ poor vision _____ poor vision _____ eyes feel hot at night

Heart and Associated TCM Functions:

_____ palpitations _____ irregular heart beat _____ pacemaker _____ insomnia
_____ poor sleep _____ chest pain _____ mental confusion _____ anxiety
_____ chest pain arm to shoulder _____ restlessness
_____ sore on tip on tongue

Kidney and Associated TCM Functions:

_____ low back pain/weakness _____ weak or sore knees _____ cold sensation in low back
_____ cold sensation in knees _____ wake at night to urinate _____ kidney stones
_____ bladder/kidney/urinary infection _____ memory problems
_____ lack of bladder control _____ feel fearful _____ excessive hair loss/balding
_____ easily startled _____ frequent broken bones _____ frequent cavities
_____ Libido_____normal_____high_____low

Urination:
_____ normal color _____ reddish _____ with blood _____ dark yellow
_____ clear _____ cloudy _____ scanty _____ scanty
_____ profuse _____ painful _____ dribbling _____ urgent
_____ difficult _____ other:____

For Women ONLY:

Are you pregnant: _____ Age of first period: _____ Number of pregnancies: _____
Number of live births: _____ Are you having or have had difficulty conceiving? _____
Are your menses regular or irregular? _____ Is your flow heavy or light? _____
How many days does your period last? _____ How many days between periods? _____

Do you experience any of the following symptoms before or during your period?
_____ abdominal cramps _____ food cravings _____ breast tenderness/swelling
_____ headaches/migraines _____ depression _____ moodiness
_____ dull pain _____ sharp pain

For Men ONLY:

Do you experience any of the following?
_____ swollen testes _____ testicular pain _____ impotence
_____ coldness or numbness in genitalia

Other: ____

Patient's Signature Date