4: HEALTH HISTORY

Important Health Issues:

- ☐ Bleeding problems: bruising easily, anticoagulation, antiplatelet therapy, thrombocytopenia, liver cirrhosis
- ☐ Daily pain medications
- ☐ Extremity swelling, lymphedema
- ☐ Frequent skin infections
- ☐ Immune deficiency: cancer, HIV, chemotherapy, neutropenia
- ☐ Implants: artificial joints, breast implants, etc.
- ☐ Implanted electronic devices: pacemaker, defibrillator, vagus stimulator, etc.
- ☐ Kidney failure, dialysis
- ☐ Propensity to form keloids
- ☐ Pregnancy (current or trying to conceive)
- ☐ Prosthetic heart valves, history of endocarditis
- ☐ Recent surgeries and/or invasive procedures, open wounds
- ☐ Severe anxiety

Medications (prescription, OTC, herbs, supplements, vitamins, etc.):

Current Medication & Dosage	Reason for Taking	Effective	Side Effects
		☐ Yes ☐ No	☐ Yes ☐ No
		☐ Yes ☐ No	☐ Yes ☐ No
		☐ Yes ☐ No	☐ Yes ☐ No
		☐ Yes ☐ No	☐ Yes ☐ No
		☐ Yes ☐ No	☐ Yes ☐ No
		☐ Yes ☐ No	☐ Yes ☐ No

Allergies:

Medication	Reaction

Significant Health Evens (surgeries, hospitalizations, accidents, injuries, etc.):

Health Event	Approximate Year

Ongoing or Frequent Use of the Following?

- ☐ Alcohol
- ☐ Antacids
- ☐ Antibiotics
- ☐ Anticoagulants, aspirin, other blood-thinners
- ☐ Anti-inflammatory (Ibuprofen, Naproxen), corticosteroids
- ☐ Cigarettes or other tobacco products
- ☐ Recreational drugs
- ☐ Sleeping pills
- ☐ Strong pain medications (Vicodin, Tramadol, etc.)

Family Health:

Medical Condition	**Parent**	**Sibling**	**Child**
Allergies, asthma	☐	☐	☐
Autoimmune disease	☐	☐	☐
Dementia	☐	☐	☐
Diabetes	☐	☐	☐
Genetic disorder	☐	☐	☐
Heart disease/attack	☐	☐	☐
Mental health issues	☐	☐	☐

Recent Laboratory Studies:

Study	Year	Result

Recent Imaging Studies (X-ray, MRI, ECG, etc.):

Study	Year	Result

Recent Specialty Visits:

Specialist	Year	Result

REVIEW OF SYSTEMS

Please check off the symptoms/statements if they apply to you.

ENERGY
- ☐ Brain fog and fatigue (feeling tired, sluggish, sleepy) especially after meals
- ☐ Feeling irritable, shaky, light-headed if meals missed
- ☐ Other ____

ENVIRONMENTAL SENSITIVITIES
- ☐ Allergies
- ☐ Feeling cold, especially hands and feet (likes to wear socks at night)
- ☐ Feeling hot not relieved by sweating or drinking
- ☐ Multiple chemical sensitivities
- ☐ Sensitivity to bright light
- ☐ Sensitivity to noise, bright light, temperature changes
- ☐ Sensitivity to wind (dislike of air conditioning or fans)
- ☐ Symptoms get worse in cold weather
- ☐ Symptoms get worse in hot weather
- ☐ Other ____

FLUID MANAGEMENT
- ☐ Concentrated or very light urine
- ☐ Leg swelling, especially in the evening
- ☐ Often thirsty with desire to drink cold fluids
- ☐ Often thirsty without desire to drink fluids
- ☐ Puffiness around eyes
- ☐ Sweating with little or no exertion (especially chest)
- ☐ Other ____

EYES
- ☐ Dark circles around eyes
- ☐ Dry eyes
- ☐ Poor vision
- ☐ Red irritated eyes
- ☐ Other ____

EARS
- ☐ Ear ringing: high pitched tinnitus
- ☐ Ear ringing: low humming, buzzing
- ☐ Hearing loss
- ☐ Other ____

NOSE

☐ Distorted or lost sense of smell
☐ Excessive mucus, post-nasal drip
☐ Frequent nosebleeds
☐ Nasal obstruction, congestion
☐ Sinus fullness and/or headaches
☐ Other ____

THROAT

☐ Difficulty swallowing
☐ Feeling of something stuck in throat
☐ Hoarseness
☐ Other ____

MOUTH & TEETH

☐ Bleeding gums
☐ Clenching of teeth at night
☐ Dental or jaw problems
☐ Dry mouth
☐ Frequent canker (aphthous) ulcers
☐ Sore tongue
☐ Weird taste in mouth
☐ Other ____

HEART

☐ Chest pain with activity
☐ Hypertension (high blood pressure)
☐ Heart disease
☐ Skipped heart beats, palpitations, arrhythmia
☐ Other ____

BLOOD AND CIRCULATION

☐ Anemia
☐ Ankle discoloration, ulcers
☐ Cramping of buttocks and/or calves when walking
☐ Dizziness (lightheadedness) when standing up quickly
☐ Easy blushing of face, chest, neck, ears
☐ Other ____

IMMUNE SYSTEM

☐ Autoimmune condition
☐ Fibromyalgia
☐ Frequent colds
☐ Lymph node swelling
☐ Other ____

BREATHING

☐ Asthma
☐ COPD, emphysema
☐ Frequent bronchitis
☐ Persistent dry cough
☐ Other ____

DIGESTION

☐ Acid reflux, GERD, heartburn
☐ Burping, belching, sour regurgitation (esp. after meals)
☐ Celiac disease
☐ Fullness, pressure, and/or bloating after meals
☐ Pain, cramping, fullness of right flank (under rib cage) especially after fatty meals
☐ Waking at night with stomach pain
☐ Other ____

BOWELS

☐ Alternate between constipation and diarrhea
☐ Constipation (infrequent or hard/dry stool)
☐ Diarrhea (frequent or soft/loose stool)
☐ Dizzy or weak after bowel movements
☐ Feeling that bowels do not empty completely
☐ Greasy or high-fat foods cause distress
☐ Inflammatory bowel disease (Crohn's or UC)
☐ Irregular bowel movements
☐ Irritable bowel syndrome (IBS)
☐ Shiny or loose, floating stools
☐ Undigested food in stools
☐ Other ____

ENDOCRINE SYSTEM

☐ Diabetes
☐ Difficulty losing weight, insulin resistance
☐ Recent weight loss or gain
☐ Thyroid issues
☐ Other ____

URINE PRODUCTION & ELIMINATION

☐ Frequency, urgency, burning
☐ Frequent urinary tract infections
☐ Interstitial cystitis
☐ Kidney disease
☐ Urine loss with coughing
☐ Other ____

MEN'S HEALTH

- ☐ Prostate issues: weak stream, straining, retention
- ☐ Weak erections
- ☐ Other ______________________________

WOMEN'S HEALTH

- ☐ Abnormal cycle and/or menstrual flow
- ☐ Breast problems
- ☐ Dizzy or light-headed around menses (period)
- ☐ Endometriosis or uterine fibroids
- ☐ Menopause
- ☐ PCOS
- ☐ Other ______________________________

SKIN & NAILS

- ☐ Acne and/or greasy skin
- ☐ Graying hair
- ☐ Dry hair and/or nails
- ☐ Excessive facial hair growth
- ☐ Eczema, dryness, itching
- ☐ Hair loss
- ☐ Nails changes (pitting, ridges, color, thickness)
- ☐ Rash
- ☐ Reddened palms
- ☐ Other ______________________________

NERVOUS SYSTEM

- ☐ Balance and/or coordination issues
- ☐ Dizziness, fainting
- ☐ Epilepsy, seizures
- ☐ Hypersensitivities to touch, tingling, numbness
- ☐ Tremors or twitching
- ☐ Other ______________________________

STRESS

- ☐ Anxiety, panic attacks, nervousness
- ☐ Depression
- ☐ History of abuse/trauma
- ☐ Mental fogginess
- ☐ Mood swings, irritability
- ☐ Poor attention and concentration
- ☐ Prone to over-thinking and worry
- ☐ Stressed-out
- ☐ Other ______________________________

SLEEP

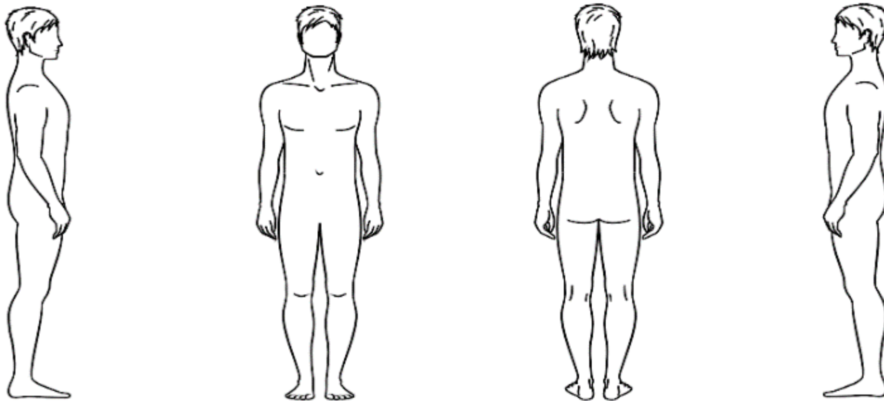
- ☐ Insomnia
- ☐ Sleep apnea, snoring, daytime sleepiness
- ☐ Symptoms interfering with sleep
- ☐ Using sleeping aids
- ☐ Vivid or bad dreams
- ☐ Other ______________________________

PAIN ASSESSMENT

- ☐ Headache
- ☐ Facial pain
- ☐ Jaw pain
- ☐ Neck pain
- ☐ Upper back pain
- ☐ Shoulder pain
- ☐ Arm pain
- ☐ Elbow pain
- ☐ Forearm pain
- ☐ Wrist pain
- ☐ Hand pain
- ☐ Finger pain
- ☐ Chest wall pain
- ☐ Midback pain
- ☐ Low back pain
- ☐ Abdominal pain
- ☐ Pelvic pain
- ☐ Hip pain
- ☐ Thigh pain
- ☐ Knee pain
- ☐ Lower leg pain
- ☐ Ankle pain
- ☐ Heel pain
- ☐ Foot pain
- ☐ Toe pain
- ☐ Other ______________________________

A PICTURE IS WORTH A THOUSAND WORDS

On the picture below, please indicate the location(s) of your pain, numbness, tingling, burning, etc.



HOW LIVING WITH PAIN AFFECTS YOU?

____

____

____

REASONS FOR TRYING ACUPUNCTURE THERAPY (CC)

Reason 1 (main)	
Reason 2 (secondary)	
How would you expect acupuncture to benefit you?	☐ Less pain ☐ Less pain medication ☐ Sleep better ☐ More energy ☐ Improve mobility ☐ Enjoy recreation ☐ Work more ☐ Exercise more ☐ Travel more ☐ Better mood

Reason/Symptom/Problem 1 (main reason for visit)

Symptom/Problem:	
Location:	
How long have you had it?	
How did it start? How did it change?	☐ Accident/trauma ☐ Sudden onset during normal activity ☐ Gradually ☐ Long-standing problem ☐ Symptoms stable for years ☐ Recent re-injury/exacerbation ☐ Recent falls ☐ Other:
How often is it present?	☐ Occasionally ☐ Frequently/daily ☐ Constantly
If you have pain, what type of pain is it?	☐ Dull ☐ Sharp ☐ Stabbing ☐ Burning ☐ Pounding ☐ Numbing ☐ Shooting ☐ Other:
What triggers/worsens your symptoms?	☐ Certain movements ☐ Bending/turning ☐ Standing ☐ Sitting ☐ Walking ☐ Sleeping ☐ Straining, coughing ☐ Weather changes ☐ Stress ☐ Other
What improves your pain/problem?	☐ Physical therapy ☐ Acupuncture ☐ Medications ☐ Rest ☐ Stretching ☐ Lying down ☐ Walking ☐ Meditation, prayer ☐ Other:
How long does relief last?	☐ Days ☐ Hours ☐ Minutes ☐ Nothing works
Have you seen anybody?	☐ Primary care provider ☐ Specialist ☐ Other:
What was the diagnosis?	
What treatments have you tried?	☐ Medications ☐ Physical therapy ☐ Acupuncture ☐ Chiropractic ☐ Injections/nerve blocks ☐ Surgery ☐ Other:
How do(es) symptoms/pain affect your life?	☐ Interferes with daily activities ☐ Interrupts sleep ☐ Makes it difficult to stay active ☐ Causes depression
Pain level past 2 weeks:	Worst (most pain): /10 Best (least pain): /10
Pain level goal:	/10

Reason/Symptom/Problem 2 (secondary reason for visit)

Symptom/Problem:	
Location:	
How long have you had it?	
How did it start? How did it change?	☐ Accident/trauma ☐ Sudden onset during normal activity ☐ Gradually ☐ Long-standing problem ☐ Symptoms stable for years ☐ Recent re-injury/exacerbation ☐ Recent falls ☐ Other:
How often is it present?	☐ Occasionally ☐ Frequently/daily ☐ Constantly
If you have pain, what type of pain is it?	☐ Dull ☐ Sharp ☐ Stabbing ☐ Burning ☐ Pounding ☐ Numbing ☐ Shooting ☐ Other:
What triggers/worsens your symptoms?	☐ Certain movements ☐ Bending/turning ☐ Standing ☐ Sitting ☐ Walking ☐ Sleeping ☐ Straining, coughing ☐ Weather changes ☐ Stress ☐ Other
What improves your pain/problem?	☐ Physical therapy ☐ Acupuncture ☐ Medications ☐ Rest ☐ Stretching ☐ Lying down ☐ Walking ☐ Meditation, prayer ☐ Other:
How long does relief last?	☐ Days ☐ Hours ☐ Minutes ☐ Nothing works
Have you seen anybody?	☐ Primary care provider ☐ Specialist ☐ Other:
What was the diagnosis?	
What treatments have you tried?	☐ Medications ☐ Physical therapy ☐ Acupuncture ☐ Chiropractic ☐ Injections/nerve blocks ☐ Surgery ☐ Other:
How do(es) symptoms/pain affect your life?	☐ Interferes with daily activities ☐ Interrupts sleep ☐ Makes it difficult to stay active ☐ Causes depression
Pain level past 2 weeks:	Worst (most pain): /10 Best (least pain): /10
Pain level goal:	/10

Print Name: Patient / Responsible party

Sign Name: Patient / Responsible party

Salud

Date