HEALTH HISTORY

Patient Name ______________________ Date of Birth ______________

Important health issues

- ☐ Bleeding problems: bruising easily, anticoagulation, antiplatelet therapy, thrombocytopenia, liver cirrhosis
- ☐ Chronic extremity swelling, lymphedema
- ☐ Chronic pain medications
- ☐ 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
- ☐ 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

Allergies

Medication	Reaction

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

Health Event	Approximate Year

Ongoing or frequent use of any of the following

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

Family Health

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

Work/Career

☐ Working ☐ Retired ☐ Disabled ☐ Unemployed ☐ Student ☐ Other

Recent Laboratory Studies

Study	Year	Result

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

Study	Year	Result

Recent Specialty Visit

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 on 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 ____________________

TEETH

- ☐ Clenching of teeth at night
- ☐ Dental or jaw problems
- ☐ Other ____________________

MOUTH

- ☐ Bleeding gums
- ☐ 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
- ☐ Gallbladder issues (inflammation, stones, removal)
- ☐ Waking at night with stomach pain
- ☐ Pain, cramping, fullness of right flank (under rib cage)
- ☐ 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

- ☐ 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
- ☐ PCOS
- ☐ Menopause
- ☐ Other ______________________________

SKIN

- ☐ Acne and/or greasy skin
- ☐ Color changes
- ☐ Dry hair
- ☐ Eczema, dryness, itching
- ☐ Excessive facial hair growth
- ☐ Hair loss
- ☐ Rash
- ☐ Reddened palms
- ☐ Other ______________________________

NAILS

- ☐ Dry, brittle
- ☐ Pitting, ridges
- ☐ Thick, yellow
- ☐ 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

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

PAIN

- ☐ 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 ____________________

REASONS FOR YOUR VISIT

Reason 1 (main)	
Reason 2 (secondary)	
How would you expect acupuncture to help?	☐ Have less pain ☐ Decrease dose of pain medication ☐ Sleep better ☐ Increase energy ☐ Improve mobility ☐ Enjoy recreation ☐ Work more ☐ Exercise more ☐ Travel ☐ Improve mood

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

Symptom/Problem:	
Location:	
How long have you had it?	
How often is it present?	☐ Occasionally ☐ Frequently/daily ☐ Constantly
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
If you have pain, what type of pain is it?	☐ Dull ☐ Sharp ☐ Stabbing ☐ Burning ☐ Pounding ☐ Numbing ☐ Shooting ☐ Other:
What aggravates your pain/problem?	☐ Certain movements ☐ Bending/turning ☐ Standing ☐ Sitting ☐ Walking ☐ Sleeping ☐ Straining, coughing ☐ Cold ☐ Wind ☐ 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
Who have you consulted?	☐ Primary care ☐ Specialist ☐ Chiropractor ☐ Acupuncturist
What was the diagnosis?	
Previous treatments tried:	☐ Medications ☐ Physical therapy ☐ Injections/nerve blocks ☐ Chiropractic ☐ Surgery ☐ Other:
How do(es) symptoms/pain affect your life?	☐ Interferes with my daily activities ☐ Interrupts sleep ☐ Makes it difficult to stay active ☐ Causes depression
Pain level past 2 weeks:	Worst: /10 Best: /10
Pain level goal:	/10

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

Symptom/Problem:	
Location:	
How long have you had it?	
How often is it present?	☐ Occasionally ☐ Frequently/daily ☐ Constantly
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
If you have pain, what type of pain is it?	☐ Dull ☐ Sharp ☐ Stabbing ☐ Burning ☐ Pounding ☐ Numbing ☐ Shooting ☐ Other:
What aggravates your pain/problem?	☐ Certain movements ☐ Bending/turning ☐ Standing ☐ Sitting ☐ Walking ☐ Sleeping ☐ Straining, coughing ☐ Cold ☐ Wind ☐ 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
Who have you consulted?	☐ Primary care ☐ Specialist ☐ Chiropractor ☐ Acupuncturist
What was the diagnosis?	
Previous treatments tried:	☐ Medications ☐ Physical therapy ☐ Injections/nerve blocks ☐ Chiropractic ☐ Surgery ☐ Other:
How do(es) symptoms/pain affect your life?	☐ Interferes with my daily activities ☐ Interrupts sleep ☐ Makes it difficult to stay active ☐ Causes depression
Pain level past 2 weeks:	Worst: /10 Best: /10
Pain level goal:	/10