Health History Questionnaire and Registration

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PATIENT INFORMATION

Date_____

Name_____

Address_____

_____

Age_____ Birthdate_____

Occupation_____

How did you hear about us?_____

CONTACT INFORMATION

Phone (1)_____

Phone (2)_____

Email_____

EMERGENCY CONTACT

Name_____

Relationship_____

Phone_____

Please check that which applies:

EXERCISE
□ none
□ moderate
□ heavy

DIET
□ vegan
□ vegetarian
□ foods excluded _____

HABITS
□ smoking packs/day_____
□ alcohol drinks/week_____
□ coffee/caffeine cups/day_____

HEALTH HISTORY

What are your primary concerns for treatment?

1_____

2_____

3_____

Have you had acupuncture before? □ yes □ no

How is your sleep?_____

How is your digestion?_____

_____

List medications or supplements you are taking:

_____

_____

_____

List serious illnesses, accidents, and surgeries:

_____

_____

When was your last complete medical exam?

_____

Please check conditions you have or had in the past:

□ AIDS/ HIV
□ Allergies
□ Arthritis
□ Bleeding disorders
□ Breast Lumps
□ Cancer

Please check the illness that pertains to blood relatives:

□ Arthritis
□ Blood disorders
□ Cancer
□ Diabetes
□ Heart disease
□ High blood pressure
□ Kidney disease
□ Seizures
□ Stroke
□ Thyroid disease

Please check the symptoms you have:

- □ Depression
- □ Difficulty focusing
- □ Dizziness
- □ Easily startled
- □ Excessive worry
- □ Excessive anger
- □ Excessive fear
- □ Fatigue/Tiredness
- □ Headaches
- □ Poor sleep
- □ Nervousness
- □ Irritablity
- □ Overwhelmed by life
- □ Loss or gain of weight

MUSCLE / JOINT / BONES

- □ Tremors or Cramps
- □ Swollen joints

Pain, weakness, or numbness in:

- □ Arms
- □ Shoulders
- □ Neck
- □ Back
- □ Legs, Hips
- □ Hands, Fingers
- □ Feet, Toes
- □ Other_____

EYES / EAR / NOSE / THROAT / RESPIRATORY

- □ Asthma, wheezing
- □ Blurred or failing vision
- □ Difficulty breathing
- □ Earache
- □ Enlarged glands
- □ Eye pain
- □ Frequent colds
- □ Nasal congestion
- □ Loss of voice
- □ Gum problems
- □ Nose bleeds
- □ Loss of hearing
- □ Persistent cough
- □ Ringing in ears
- □ Sinus problems
- □ Post nasal drip

SKIN

- □ Boils □ Itching / Rash
- □ Bruise easily
- □ Dry skin
- □ Sweating
- □ Sensitive skin
- □ Non-healing sores
- □ Acne

CARDIOVASCULAR

- □ Chest pain
- □ Pain over heart
- □ Previous heart attack
- □ Swelling of ankles
- □ Hardening of arteries
- □ Poor circulation
- □ Rapid/irregular heartbeat

GASTROINTESTINAL

- □ Belching, gas, or bloating
- □ Colon problems
- □ Constipation
- □ Diarrhea
- □ Difficulty swallowing
- □ Distention of abdomen
- □ Excessive hunger
- □ Gallbladder problems
- □ Hemorrhoids
- □ Indigestion
- □ Nausea
- □ Pain over stomach
- □ Poor appetite
- □ Vomiting

GENITO / URINARY

- □ Blood/ pus in urine
- □ Frequent urination
- □ Inability to control urine
- □ Urinary tract infection
- □ Kidney infection
- □ Kidney stones
- □ Lowered libido

MEN ONLY

- □ Erectile dysfunction
- □ Premature ejaculation
- □ Discharge from penis
- □ Other_____
- □ Infertilty
- □ STD
- □ Prostate problems

WOMEN ONLY

Are you pregnant? □ Yes □ No

Age of first period_____

Date of last period_____

Age of menopause_____

Color of menstrual flow:

- □ Light red
- □ Bright red
- □ Dark red
- □ Purple
- □ Brown
- □ Black

- □ Bleeding between periods
- □ Heavy flow
- □ Irregular cycle
- □ Previous miscarriage
- □ Fibroids
- □ Other_____
- □ Clots
- □ Light flow
- □ PMS
- □ STD
- □ Cysts

The information on this form is correct to the best of my knowledge.

X Patient Signature _____ **Date** _____