

Health History Questionnaire and Registration



Sun Cho Acupuncture
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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:

- | | |
|--|---|
| <input type="checkbox"/> Depression | <input type="checkbox"/> Fatigue/Tiredness |
| <input type="checkbox"/> Difficulty focusing | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Poor sleep |
| <input type="checkbox"/> Easily startled | <input type="checkbox"/> Nervousness |
| <input type="checkbox"/> Excessive worry | <input type="checkbox"/> Irritability |
| <input type="checkbox"/> Excessive anger | <input type="checkbox"/> Overwhelmed by life |
| <input type="checkbox"/> Excessive fear | <input type="checkbox"/> Loss or gain of weight |

MUSCLE / JOINT / BONES

- | | |
|--|---|
| <input type="checkbox"/> Tremors or Cramps | <input type="checkbox"/> Swollen joints |
|--|---|
- Pain, weakness, or numbness in:
- | | |
|------------------------------------|---|
| <input type="checkbox"/> Arms | <input type="checkbox"/> Legs, Hips |
| <input type="checkbox"/> Shoulders | <input type="checkbox"/> Hands, Fingers |
| <input type="checkbox"/> Neck | <input type="checkbox"/> Feet, Toes |
| <input type="checkbox"/> Back | <input type="checkbox"/> Other _____ |

EYES / EAR / NOSE / THROAT / RESPIRATORY

- | | |
|--|---|
| <input type="checkbox"/> Asthma, wheezing | <input type="checkbox"/> Loss of voice |
| <input type="checkbox"/> Blurred or failing vision | <input type="checkbox"/> Gum problems |
| <input type="checkbox"/> Difficulty breathing | <input type="checkbox"/> Nose bleeds |
| <input type="checkbox"/> Earache | <input type="checkbox"/> Loss of hearing |
| <input type="checkbox"/> Enlarged glands | <input type="checkbox"/> Persistent cough |
| <input type="checkbox"/> Eye pain | <input type="checkbox"/> Ringing in ears |
| <input type="checkbox"/> Frequent colds | <input type="checkbox"/> Sinus problems |
| <input type="checkbox"/> Nasal congestion | <input type="checkbox"/> Post nasal drip |

SKIN

- | | |
|--|--|
| <input type="checkbox"/> Boils | <input type="checkbox"/> Itching / Rash |
| <input type="checkbox"/> Bruise easily | <input type="checkbox"/> Sensitive skin |
| <input type="checkbox"/> Dry skin | <input type="checkbox"/> Non-healing sores |
| <input type="checkbox"/> Sweating | <input type="checkbox"/> Acne |

CARDIOVASCULAR

- | | |
|--|--|
| <input type="checkbox"/> Chest pain | <input type="checkbox"/> Hardening of arteries |
| <input type="checkbox"/> Pain over heart | <input type="checkbox"/> Poor circulation |
| <input type="checkbox"/> Previous heart attack | <input type="checkbox"/> Rapid/irregular heartbeat |
| <input type="checkbox"/> Swelling of ankles | |

GASTROINTESTINAL

- | | |
|---|---|
| <input type="checkbox"/> Belching, gas, or bloating | <input type="checkbox"/> Gallbladder problems |
| <input type="checkbox"/> Colon problems | <input type="checkbox"/> Hemorrhoids |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Indigestion |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Nausea |
| <input type="checkbox"/> Difficulty swallowing | <input type="checkbox"/> Pain over stomach |
| <input type="checkbox"/> Distention of abdomen | <input type="checkbox"/> Poor appetite |
| <input type="checkbox"/> Excessive hunger | <input type="checkbox"/> Vomiting |

GENITO / URINARY

- | | |
|---|---|
| <input type="checkbox"/> Blood/ pus in urine | <input type="checkbox"/> Kidney infection |
| <input type="checkbox"/> Frequent urination | <input type="checkbox"/> Kidney stones |
| <input type="checkbox"/> Inability to control urine | <input type="checkbox"/> Lowered libido |
| <input type="checkbox"/> Urinary tract infection | |

MEN ONLY

- | | |
|--|--|
| <input type="checkbox"/> Erectile dysfunction | <input type="checkbox"/> Infertility |
| <input type="checkbox"/> Premature ejaculation | <input type="checkbox"/> STD |
| <input type="checkbox"/> Discharge from penis | <input type="checkbox"/> Prostate problems |
| <input type="checkbox"/> Other _____ | |

WOMEN ONLY

- Are you pregnant? Yes No
- Age of first period _____
- Date of last period _____
- Age of menopause _____

Color of menstrual flow:

- | | | |
|------------------------------------|-------------------------------------|-----------------------------------|
| <input type="checkbox"/> Light red | <input type="checkbox"/> Bright red | <input type="checkbox"/> Dark red |
| <input type="checkbox"/> Purple | <input type="checkbox"/> Brown | <input type="checkbox"/> Black |
- | | |
|---|-------------------------------------|
| <input type="checkbox"/> Bleeding between periods | <input type="checkbox"/> Clots |
| <input type="checkbox"/> Heavy flow | <input type="checkbox"/> Light flow |
| <input type="checkbox"/> Irregular cycle | <input type="checkbox"/> PMS |
| <input type="checkbox"/> Previous miscarriage | <input type="checkbox"/> STD |
| <input type="checkbox"/> Fibroids | <input type="checkbox"/> Cysts |
| <input type="checkbox"/> Other _____ | |

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

X Patient Signature _____ Date _____