Date _____

Name _____ SSN _____
Address_____ City/State _____ Zip _____
Home Phone _____Date of Birth _____ Age _____ Gender M/F
Work Phone_____ Cell Phone_____
Place of Birth _____ Referred By _____
Employer _____ Occupation _____
Approximate Hours Per Week Worked _____ Retired? _____
Married___ Separated___ Divorced___ Widowed___ Single___ Partnership___
Live With: Spouse ___ Partner ___ Parents ___ Children ___ Friends ___ Alone ___
Emergency Contact _____ Phone _____ Relation _____

HEALTH HISTORY QUESTIONNAIRE

What Are Your Most Important Health Problems? List in Order of Importance.
1. _____
2. _____
3. _____

Are You Currently Receiving Healthcare at Another Facility?
If Yes, Name of Practitioner? _____
List Any Hospitalizations or Surgeries You've Had w/ Dates: _____
_____
List Any X-Rays, CAT Scans or MRIs You've Had w/ Dates: _____
_____
Height _____ Weight _____ Weight One Year Ago _____ Max Weight _____
When is Your Energy Level the Best _____ Worst _____

FAMILY HISTORY: Are You Adopted? _____
List All Significant Diseases (i.e.: cancer, diabetes) of Immediate Family Members:
Father _____ Mother _____
Siblings _____ Aunts / Uncles _____
Grandfather _____ Grandmother _____

Smoking Y N P _____ Frequency
Alcohol Y N P _____ Frequency
Exercise Y N P _____ Frequency

MEDICATIONS: Are You Currently Taking Any of the Following **(Circle) :**
Laxatives / Pain Relievers / Appetite Suppressant / Antacids / Antibiotics / Sleep Aids / Thyroid Meds. / Cortisone / Tranquilizers /
List Any Prescriptions, Over the Counter, Vitamins or Supplements You're Taking.
1._____ 2. _____ 3. _____
4. _____ 5. _____ 6. _____

SYMPTOM REVIEW

Y= Current Problem * N= Never Had * P= Had Before, Not Currently

EMOTIONAL			
Mood Swings	Y N P	Depression	Y N P
Considered/Attempted Suicide	Y N P	Anxiety or Nervousness	Y N P
ENDOCRINE			
Hypothyroid	Y N P	Heat/Cold Intolerance	Y N P
Hypoglycemia	Y N P	Diabetes	Y N P
Excessive thirst	Y N P	Excessive hunger	Y N P
Fatigue	Y N P	Seasonal depression	Y N P
IMMUNE			
Chronic Fatigue Syndrome	Y N P	Chronic Infections	Y N P
Chronically swollen glands	Y N P	Slow wound healing	Y N P
NEUROLOGIC			
Seizures	Y N P	Paralysis	Y N P
Muscle weakness	Y N P	Numbness/tingling	Y N P
Loss of memory	Y N P	Dizziness	Y N P
Vertigo	Y N P	Loss of balance	Y N P
SKIN			
Rashes	Y N P	Eczema, Hives	Y N P
Acne, Boils	Y N P	Itching	Y N P
Lumps	Y N P	Night sweats	Y N P
HEAD			
Headaches	Y N P	Head Injury	Y N P
Migraine	Y N P	Jaw /TMJ	Y N P
EYES			
Spots in eyes	Y N P	Cataracts	Y N P
Eye pain, strain	Y N P	Tearing or dryness	Y N P
EARS			
Impaired hearing	Y N P	Ringing	Y N P
Earaches	Y N P	Dizziness	Y N P

.

Y = Current Problem N = Never Had P = Had Before, Not Currently

NOSE AND SINUSES

Frequent colds	Y N P		
Stuffiness	Y N P	Hay fever	Y N P
Sinus problems	Y N P		

MOUTH AND THROAT

Frequent sore throat	Y N P	Sore tongue, lips	Y N P
Teeth grinding	Y N P		
Jaw clicks	Y N P		

NECK

Lumps	Y N P	Swollen glands	Y N P
Goiter	Y N P	Pain or stiffness	Y N P

RESPIRATORY

Cough	Y N P	Asthma	Y N P
Wheezing	Y N P	Bronchitis	Y N P
Pneumonia	Y N P	Shortness of breath	Y N P

CARDIOVASCULAR

Heart disease	Y N P	Chest pain	Y N P
High/low blood pressure	Y N P	Fainting	Y N P
Palpitations/fluttering	Y N P	Swelling in ankles	Y N P

GASTROINTESTINAL

Trouble swallowing	Y N P	Heartburn	Y N P
Change in thirst	Y N P	Hemorrhoids	Y N P
Nausea	Y N P	Vomiting	Y N P
Blood in stool	Y N P	Bowel Movements: how often _____	
Constipation	Y N P	Is this a change_____	
Belching	Y N P	Diarrhea	Y N P
Passing gas	Y N P	Gall bladder disease	Y N P

URINARY

Pain on urination	Y N P	Increased frequency	Y N P
Frequency at night	Y N P	Inability to hold urine	Y N P
Frequent infections	Y N P	Kidney stones	Y N P

MALE REPRODUCTION

Hernias	Y N P	Prostate disease	Y N P
Impotence	Y N P		

Y = Current Problem N = Never Had P = Had Before, Not Currently

FEMALE REPRODUCTION

Age of first menses	_____	Are cycles regular	_____
Length of cycles	_____ days	Bleeding between cycles	Y N P
Duration of menses	_____ days	Clotting	Y N P
Painful menses	Y N P	Discharge	Y N P
Heavy or excessive flow	Y N P	Birth control	Y N P
PMS	Y N P	Type of birth control	_____
If yes, what are your symptoms		Number of pregnancies	_____
_____		Number of live births	_____
Endometriosis	Y N P	Number of miscarriages	_____
Ovarian cysts	Y N P	Number of abortions	_____
Difficulty conceiving	Y N P	Menopausal symptoms	_____
Venereal disease	Y N P	_____	

MUSCULOSKELETAL

Joint pain or stiffness	Y N P	Arthritis	Y N P
Broken bones	Y N P	Weakness	Y N P
Muscle spasms or cramps	Y N P	Sciatica	Y N P

BLOOD / PERIPHERAL VASCULAR

Easy bleeding or bruising	Y N P	Anemia	Y N P
Cold hands/feet	Y N P	Varicose veins	Y N P

Comments/Questions:_____
_____
_____

_____ _____
SIGNATURE DATE

CONSENT FORM

I understand that acupuncture is performed by the insertion of needles through the skin at certain points on the body in an attempt to treat bodily dysfunctions or diseases, to modify or prevent pain, and to make normal the body's physiological functions. The procedure has been fully explained to me.

I have been made aware that certain adverse side effects may result. These include, but are not limited to, some local bruising, minor bleeding, fainting, temporary pain or discomfort, and possible temporary aggravation of symptoms existing prior to acupuncture treatment.

I understand that the acupuncturist may recommend substances from the Oriental materia medica to treat bodily dysfunctions or diseases, to modify or to prevent the perception of pain, and to normalize the body's physiological functions. I understand that I am not required to take these substances but must follow the directions for administration and dosage if I decide to take them.

I have been made aware that certain adverse side effects may result from taking these substances. These could include, but are not limited to, changes in bowel movement, temporary abdominal pain or discomfort, and the possible temporary aggravation of symptoms existing prior to herbal treatment. Should I experience any problems, which I associate with these substances, I should suspend taking them and contact my acupuncturist.

I have carefully read and I understand all of the above and am fully aware of what I am signing.

Signature of Patient/Guardian of Patient: _____ Date: _____

Printed Name: _____

PRIVACY POLICY: Due to HIPAA Privacy Regulations, our office is required to offer you a notice of our privacy practices. This document lets you know what steps we take in protecting your health information. Please ask the front office staff if you would like a copy.

_____ Do **not** want a copy _____ Received a copy

Signature _____ Date _____

CANCELLATION POLICY

To avoid being charged a $30 cancellation fee, I agree to give 24 hours notice.

Signature: _____ Date: _____