Classical Acupuncture Health History Form

Successful health care and preventative medicine are only possible when the practitioner has a complete understanding of the patient physically, mentally, and emotionally. Please complete this questionnaire as thoroughly as possible. Print all information clearly and indicate areas of confusion with a question mark.

I. General Patient Information: **Today's Date: _____/_____/_____**

First Name:_____ Last Name:_____

Address:_____

City:_____State_____Zip_____

Date of Birth:_____/_____/_____ Age:_____ Weight: _____lbs

Gender: M/F Martial Status: S M D W

Occupation:_____

Best number to contact you: (Please circle one - Home/Cell/Work)_____

Emergency Contact Name:_____

Emergency Contact Number:_____

II. Current Medical History:

Are you currently under the care of a physician? Y N If yes, for what?_____

Please indicate health concerns that have brought you to Ancient Healing Arts, in order of importance:

Condition Past Treatments

a. _____ _____

How long have you had this condition?_____

How did it start? _____

What treatments have you received?_____

What seems to make it better? _____

What seems to make it worse? _____

b. _____ _____

How does this condition affect you?_____

How did it start? _____

What treatments have you received?_____

What seems to make it better? _____

What seems to make it worse? _____

c. _____ _____

How does this condition affect you?_____

How did it start? _____

What treatments have you received?_____

What seems to make it better? _____

What seems to make it worse? _____

d. _____ _____

How does this condition affect you? _____

How did it start? _____

What treatments have you received?_____

What seems to make it better? _____

What seems to make it worse? _____

Please list any foods, drugs, or medications you are hypersensitive or allergic to (please indicate reaction)

_____

_____

_____

_____

Please list any dietary restrictions:_____

_____

Please list any food cravings:_____

_____

Please list any medications (prescribed and over-the-counter), vitamins, and supplements you are currently taking?

Name	Dose	Purpose	How long?

Do you have any reason to believe that you are currently pregnant? Yes No

If so, how far along are you?_____ Due date_____

III. Family History:

	Father	Mother	Siblings	Grandparents	Spouse	Children
Age (if living)	_____	_____	_____	_____	_____	_____
Health	_____	_____	_____	_____	_____	_____
Cancer	_____	_____	_____	_____	_____	_____
Diabetes	_____	_____	_____	_____	_____	_____
Heart Disease	_____	_____	_____	_____	_____	_____
HBP	_____	_____	_____	_____	_____	_____
Stroke	_____	_____	_____	_____	_____	_____
Mental Illness	_____	_____	_____	_____	_____	_____
Asthma/Etc	_____	_____	_____	_____	_____	_____
Kidney Disease	_____	_____	_____	_____	_____	_____
Age (at death)	_____	_____	_____	_____	_____	_____
Cause of death	_____	_____	_____	_____	_____	_____

IV. Past Medical History:

Childhood Illnesses (Please circle any that apply)

Scarlet Fever Diphtheria Rheumatic Fever Mumps Measles German Measles Chicken Pox

Other: _____

Immunizations (please circle any that apply)

Polio Tetanus Rubella/Mumps Pertussis Diphtheria Hib Hepatitis B

Other:_____

Hospitalizations and Surgeries

Reason	When?	Reason	When?
_____		_____	
_____		_____	
_____		_____	

X-Rays/CAT Scans/MRIs/NMR's/Special Studies

Reason	When?	Reason	When?
_____		_____	
_____		_____	
_____		_____	

V. Patient Profile:

General Symptoms (Please check any that currently apply)

___Poor/Heavy Appetite ___Cold Hands/Feet ___Dizziness/Vertigo

___Recent Weight Loss/Gain ___Fever/Chills ___Bruise/Bleed Easily

___Tired after Eating ___Sweats Easily ___Lack of Strength

___Frequent Thirst ___Night Sweats ___Muscle Cramps

___Strong like for Hot/Cold Drinks ___Poor Sleep/Insomnia ___Fatigue

___Dream-disturbed Sleep Other:_____

Head, Eyes, Ears, Nose, Throat (Please check any that currently apply)

___Poor Vision ___Teeth/Gum Problems ___Excessive Phlegm

___Eye Pain ___TMJ/Jaw Problems ___Sore Throat

___Blurred Vision ___Facial Pain ___Nosebleeds

___Floaters ___Dry Mouth ___Ringing in Ears

___Red/Itchy Eyes ___Sinus Problems ___Poor Hearing

___Tearing/Dry Eyes ___Earaches ___Headaches/Migraines

Respiratory (Please check any that currently apply)

___Difficulty Inhaling/Exhaling ___Wet/Dry Cough ___Cough with Phlegm

___Shortness of breath ___Chest Tightness ___Color of Phlegm

___Asthma Other:_____

Cardiovascular (Please check any that currently apply)

___High/Low Blood Pressure ___Palpitations ___Chest Pain

___Difficulty Breathing Other:_____

Gastrointestinal (Please check any that currently apply)

___Nausea ___Gas/Flatulence ___Diarrhea

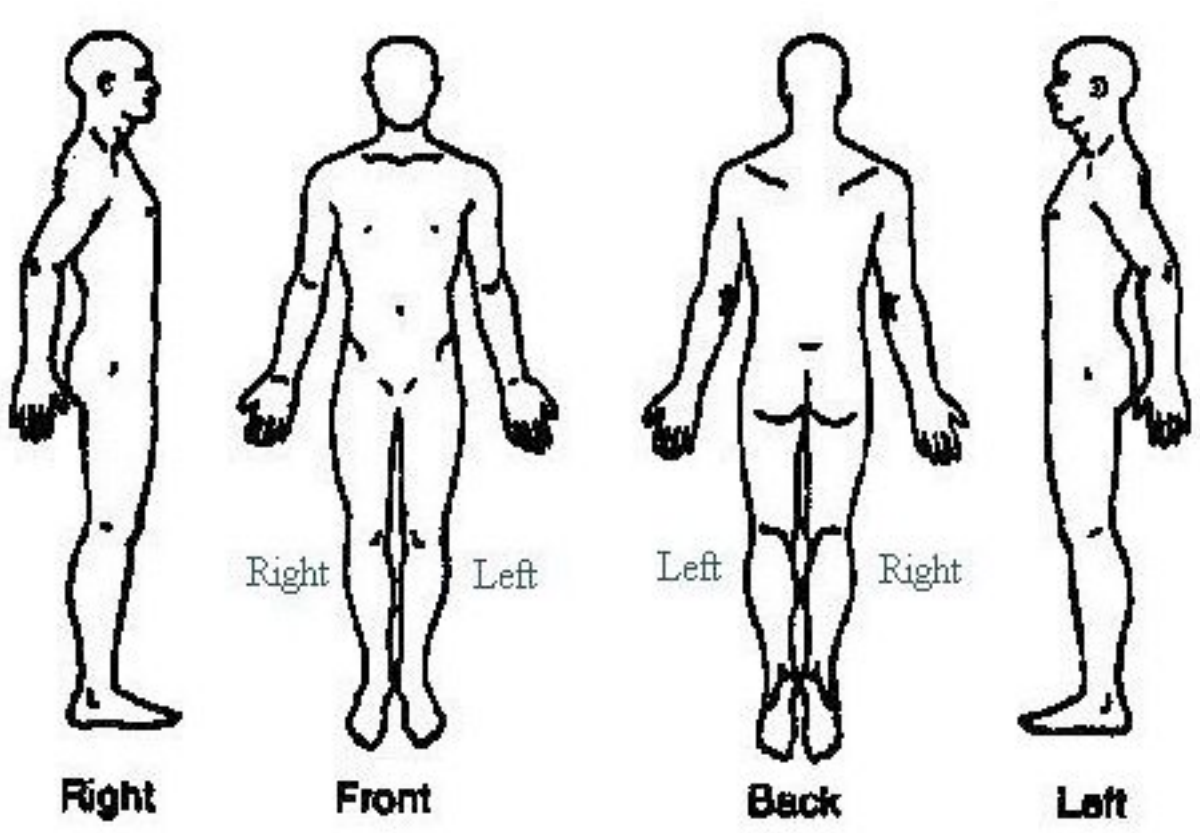
___Vomiting ___Bloating/Distention ___Constipation

___Acid Reflux/Heartburn ___Bad Breath ___Mucus/Blood in Stools

___# of Bowel Movements/Day Other:_____

Musculoskeletal

On the following Diagram, SHADE in the areas that you feel should be addressed



Describe the location of your pain/tenderness/tightness _____

_____

The pain is (check all that apply)

___Dull ___Sharp ___Stabbing ___Aching ___Numb ___Burning ___Deep

___Tingling ___Superficial ___Comes/Goes Other:_____

Please Indicate

Pain is Worse/Better with Heat	Pain is Worse/Better with Cold
Pain is Worse/Better with Pressure	Pain is Worse in the Morning/Evening
Pain is Worse/Better with Rest	Pain is Worse/Better with Movement or Activity

I have (check all that apply)

___Swollen Joints ___Arthritis ___Joint Pain ___Tendonitis ___Rheumatism ___Bone Pain

___Muscle Cramping ___Muscle Pain ___Repetitive Sprain Injury Other:_____

Skin and Hair (Please check all that currently apply)

___Rashes ___Bruises Easily ___Dandruff

___Eczema ___Dry Skin ___Hair Loss

___Hives ___Itchy Skin ___Acne

Gentio-Urinary Tract (Please check all that currently apply)

___Painful Urination ___Urgent Urination ___Wake to Urinate

___Frequent Urination ___Blood in Urine ___Difficulty Urinating

___Increased/Decrease Libido Other:_____

Gynecological (Please check all that currently apply)

___Irregular Periods ___Breast Tenderness ___Nipple Discharge

___Painful Periods ___Vaginal Discharge ___Bleeding between Cycles

___PMS ___Heavy Flow ___Menopausal Symptoms

___Clotting Other:_____

Menstrual Chart (Please fill out the chart below)

	Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7
Color (normal, bright red, pale, brown, rust, dark, purple, other)							
Amount of flow (normal, heavy, light)							
Pain/Cramps (location, dull, sharp, other)							
Clots (large, small, black, purple, red, other)							
Vomiting (check if yes)							
Nausea (check if yes)							
Other							

Menstrual/Birthing History:

Age of First Menses:_____ # of Pregnancies:_____

# of Days of Menses:_____ # of Miscarriages:_____

Length of Cycle:_____ # of Abortions:_____

Birth Control Type:_____ # of Live Births:_____

Age of Menopause:_____ # of Children:_____

Do you experience any of the following pre-menstrual syndromes (PMS)?

___Nausea ___Vomiting ___Water Retention ___Breast Swelling/Tenderness

___Headaches ___Migraines Other:_____

___Depression ___Irritability ___Anxiety Other Emotions:_____

Dull Pain: Yes No Where?_____

Sharp Pain: Yes No Where?_____

Other:_____

Male Reproductive System (Please check any that currently apply)

___Swollen Testes ___Testicular Pain ___Impotence

___Feeling of Cold in External Genitalia ___Feeling of Numbness in External Genitalia

___Premature Ejaculation ___Nocturnal Emissions ___Sexual Difficulties

Other:_____

Neuropsychological (Please check all that currently apply)

___Anxiety ___Depression ___Poor Memory

___Irritability ___Seizures ___Stress

___Mood Swings ___Nervousness ___Mental Tension

___Difficulty Concentrating ___Numbness/Tingling ___Dyslexia

___Fatigue Other:_____

What is your Favorite Season?_____ Least Favorite?_____

What is you Favorite Kinds of Food?_____ Least Favorite?_____

What is Favorite Color?_____ Least Favorite?_____

Which of the following is most important to you? (Check only one)

___Unconditional Love ___Feeling Understood ___Feeling Respected and Appreciated

___Feeling that Everything is Going to be OK ___Having a Sense of Direction

Lifestyle, Exercise, Diet, & Energy:

Describe your Level of Energy_____

What Time of the Day is your Energy the Highest?_____ Lowest?_____

Do you Fatigue Easily? Yes No What Makes you Tired?_____

What Type of Exercise do you do and How Often? _____

_____

_____

Do you: ___Smoke Cigarettes ___Smoke Marijuana ___Smoke Cigars ___Drink Alcohol ___Other

Describe your Typical Sleeping Patterns:_____

How Many Hours per Night? _____ Go to be at:_____ Wake/Get up at: _____

Do you feel Rested When you wake up? _____

Do you "Hit the Snooze" Button?_____ How many times:_____

Do you Have Difficulty: ____Falling Asleep ____Staying Asleep ___Difficult Sleeping/Toss & Turn

Wake up at _____and can't Fall Asleep Again because_____

Do you wake to Urinate? Yes No How Many Times? _____ At What Time?_____

Do you Snore? _____

Do you Typically eat Three Meals per Day? Yes No If No, How Many:_____

How Many Glasses of Water do You Drink per Day? _____

Describe your Appetite and Cravings: _____

_____

Eat Meat? Yes No # of Times/Day: _____ # of Times/Week_____

Eat Sugar? Yes No # of Times/Day:_____ # of Times/Week_____

Eat Dairy? Yes No # of Times/Day:_____ # of Times/Week_____

Average Daily Menu (Please indicate times):

Breakfast	*Snack*	*Lunch*	*Snack*	*Dinner*	*Snack*
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

How did you hear about Ancient Healing Arts? _____
If referred, name? _____