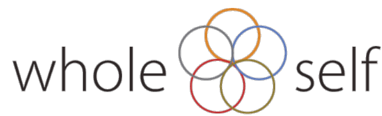

Acupuncture and Chinese Herbal Medicine

Initial Health History Intake

Date__________________

Patient Information	Contact
Last Name: ______________________________	Home phone ______________________________
First Name: ______________________________	Work phone ______________________________
Address_________________________________	Cell phone ______________________________
City State Zip____________________________	Email ___________________________________
Age_____ Birth Date__________ Gender_______	**Emergency contact:**
▫ Married ▫ Divorced ▫ Widowed ▫ Never Married	Name ___________________________________
Occupation ______________________________	Relationship_____________________________
Company name ___________________________	Home phone ______________________________
Primary physician _________________________	Work phone _____________________________
Physician phone __________________________	How did you hear about us? _______________
What is (are) your main complaint(s)?	**List medications/purpose & food supplements:**
1 ______________________________________	1 ______________________________________
How long have you had? ____________________	2 ______________________________________
Is there a diagnoses? ______________________	3 ______________________________________
Due to an injury/illness (specify)? _____________	4 ______________________________________
2 ______________________________________	5 ______________________________________
How long have you had? ____________________	**List major hospitalizations/surgeries and year/age:**
Is there a diagnoses? ______________________	1 ______________________________________
Due to an injury/illness (specify)? _____________	2 ______________________________________
3 ______________________________________	3 ______________________________________
How long have you had? ____________________	**Family Medical History**.
Is there a diagnoses? ______________________	▫ Diabetes ▫ High blood pressure ▫ High Cholesterol ▫ Stroke ▫ Cancer ▫ Heart disease ▫ Thyroid disease ▫ Seizures ▫ Mental health:__________________
Due to an injury/illness (specify)? _____________	Other:__________________________________

Symptoms	Symptoms
General Health Status: **Appetite:** ▫ Poor ▫ Good ▫ Excessive **Sleep:** ▫ Good ▫ Difficulty falling ▫ Wake >than 1x ▫ Excessive dreaming. Wake rested: ▫ Yes ▫ No **Energy** level, rate from 1-10, (10=excessive) ________ Energy dips? ▫ Yes ▫ No Time of day/night? ________ **Areas of Stress:** ▫ None ▫ Work ▫ Family ▫ School ▫ Other ______________________________________ **Diet:** Do you follow a specific diet? ▫ Yes ▫ No If yes, what type: ______________________________ Typical Breakfast ______________________________ Typical Lunch _________________________________ Typical Dinner _________________________________ Typical Snacks ________________________________ # of glasses water/day __________________________ # of cups of caffeine/day ________________________ Smoke Tobacco? ▫ Yes ▫ No How many/day? _____ Drink alcohol? ▫ Yes ▫ No How many/week? _______ Recreational drugs? ▫ Yes ▫ No How often? _______ Exercise? ▫ Yes ▫ No How often? ________________ **General Medical History**. ▫ Fevers ▫ Excessive sweating ▫ Always warm ▫ Chills ▫ Always cold ▫ Cold hands/feet ▫ Weight gain or loss ▫ Change in appetite ▫ Cravings ▫ Thirst for cold drinks ▫ Thirst for warm drinks ▫ No desire to drink ▫ Diabetes ▫ High Cholesterol ▫ High blood pressure ▫ Stroke ▫ Thyroid disease ▫ Heart disease ▫ Herpes ▫ Hepatitis ▫ HIV/AIDS ▫ Cancer, where?______________________________ Other:____	Check symptoms that have occurred in the last year: **Muscles/Joints/Bones** ▫ Frequent muscle cramps or spasms ▫ Swollen joints *Pain, weakness, and/or numbness in:* ▫ Jaw (TMJ) ▫ Shoulders ▫ Neck ▫ Arms ▫ Hands ▫ Wrist ▫ Fingers ▫ Hips ▫ Sciatica ▫ Upper Back ▫ Mid Back ▫ Low Back ▫ Legs ▫ Feet ▫ Ankle ▫ Toes ▫ Other___________________________________ **Eyes/Ears/Nose/Throat/Respiratory** ▫ Blurred or failing vision or floaters ▫ Dry, irritated or watery eyes ▫ Eye pain ▫ Ringing in the ears, tinnitus ▫ Earaches ▫ Loss of hearing ▫ Nose bleeds ▫ Sinus problems ▫ Enlarged glands ▫ Hoarseness ▫ Persistent cough, sore throat ▫ Gum trouble ▫ Asthma/wheezing ▫ Difficulty breathing ▫ Frequent colds ▫ Allergies, specify _______________________ **Skin** ▫ Boils, acne ▫ Bruise easily ▫ Dry skin ▫ Itching/rash/hives ▫ Sensitive skin ▫ Sores that won't heal ▫ Eczema ▫ Psoriasis ▫ Other ____________

Symptoms	Symptoms
Cardiovascular ▫ Chest pain ▫ Hardening of arteries ▫ High or low blood pressure ▫ Heart Pain ▫ Previous heart attack ▫ Poor circulation ▫ Rapid/irregular heart beat ▫ Swelling of ankles **Gastrointestinal** ▫ Difficulty swallowing ▫ Acid reflux/Gerd ▫ Belching ▫ Indigestion ▫ Gas ▫ Abdominal distention or bloating ▫ Nausea and/or vomiting ▫ Pain ▫ Upper abdomen ▫ Lower Abdomen ▫ Diverticulosis ▫ Polyps ▫ Cancer ▫ Colitis ▫ Crohn's ▫ IBS ▫ Other _______ ▫ Constipation ▫ Diarrhea/Loose stool ▫ Hemorrhoids ▫ Rectal bleeding ▫ Gall bladder disorder, describe _________________ **Neurological** ▫ Dizziness ▫ Loss of balance ▫ Seizure ▫ Concussion ▫ Numbness, loss of feeling ▫ Nerve pain **Psychological** ▫ Anxiety ▫ Depression ▫ Manic Depression ▫ Bipolar ▫ Bad temper, easily agitated ▫ ADD or ADHD ▫ Nervous condition or easily susceptible to stress Have you considered/attempted suicide? ▫ Yes ▫ No Have you been treated for emotional problems? ▫ Yes ▫ No	**Genito/Urinary** ▫ Frequent or night time urination ▫ Inability to control urine, dribbling, weak stream ▫ Painful urination ▫ Frequent urinary tract infections ▫ Blood/pus in urine ▫ Kidney infection/stones ▫ Kidney disease ▫ Venereal disease **Reproductive and Gynecological (women)** ▫ Bleeding between periods ▫ Scanty menstrual flow ▫ Excessive menstrual flow ▫ Clots in menses ▫ Extreme menstrual pain ▫ Irregular cycle ▫ PMS ▫ Hot flashes/night sweats ▫ Reduced libido Age of first menses _____ # of days of bleeding ____ # of days between menses ______ # of Pregnancies _____ # of Births: ______ # of Miscarriages _______ Any possibility that you be pregnant? ▫ Yes ▫ No **Reproductive (men)** ▫ Penis discharge ▫ Prostate disorder ▫ Erectile dysfunction ▫ Reduced libido **Tell us about anything you would like to discuss.** ____

My signature confirms that the information on this form is correct to the best of my knowledge.

Signature____Date_____________________