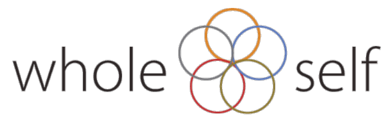

Acupuncture and Chinese Herbal Medicine

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

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:____

Symptoms

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 □ Knee □ Ankle □ 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 □ Warts

□ 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 ▫ Moderate to 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**_____________________