Client Information and Health History

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Please fill out this form as thoroughly as possible. The information provided will be used to develop an individualized plan for your treatment. All information provided is strictly confidential. If you have any questions, please ask!

Name	Date	
Address		
City	State	Zip
Phone		❑ Cell ❑ Home ❑ Work
Alternate Phone number		❑ Cell ❑ Home ❑ Work
Email address		
May I add you to the list for my monthly email newsletter?		❑ Yes ❑ No thanks
Age	Date of birth	
Emergency Contact	Relationship	
Emergency contact phone		❑ Cell ❑ Home ❑ Work
Emergency contact alternate phone		❑ Cell ❑ Home ❑ Work
How did you hear about our office?		
Primary Care Physician		
Address		
Phone		
Main reason for seeking acupuncture treatment		
How long have you had this condition?		
What else have you tried?		

Other symptoms or issues you would like to address

Please list any allergies (drugs, food, environmental)

Please list any medications you take, with the dosage, reason for taking, and any side effects you experience.

Medication	*Dosage*	*Reason*	*Side effects*

Please list any vitamins or supplements you take, the dosage, reason, and any side effects you experience.

Please list any surgeries you have had, with dates and reason for surgery.

Please list any significant injuries or illnesses with approximate dates.

Exercise

Number of days per week	Length	Type

Diet			
Number of meals per day	Snacks	Caffeinated drinks	Alcohol per week
Please note any dietary restrictions			
Do you smoke?	How much?	How long?	Quit recently?

Health History

Have you been diagnosed with any of the following health conditions:

- ❑ High/low blood pressure
- ❑ Diabetes
- ❑ Hypo/hyperglycemia
- ❑ Bleeding disorder
- ❑ Cancer
- ❑ Heart disease
- ❑ Stroke
- ❑ Lyme disease
- ❑ Seizure disorder
- ❑ Asthma
- ❑ Kidney disease
- ❑ Hepatitis
- ❑ Thyroid condition
- ❑ High cholesterol
- ❑ Asthma/allergies
- ❑ Anemia
- ❑ Other health conditions _____

Please check if you have had any of the following symptoms in the last 3 months:

Energy

- ❑ Unexplained or chronic tiredness
- ❑ Muscle weakness or fatigue
- ❑ Sudden energy drop

Temperature

- ❑ Chills/cold easily
- ❑ Fevers/heat sensation
- ❑ Cold hands or feet
- ❑ Sweats easily
- ❑ Lack of sweating
- ❑ Night sweats

Skin and hair

- ❑ Rashes
- ❑ Hives/allergic dermatitis
- ❑ Eczema
- ❑ Psoriasis
- ❑ Acne
- ❑ Loss of hair
- ❑ Itching
- ❑ Face flushing
- ❑ Bleed or bruise easily
- ❑ Soft or brittle nails
- ❑ Dry or brittle hair
- ❑ Dry skin
- ❑ Premature graying

Heart and Lungs

- ❑ Palpitations or fast heartbeat
- ❑ Irregular heartbeat
- ❑ Chest pain or pressure
- ❑ Shortness of breath
- ❑ Cough
- ❑ Asthma/wheezing
- ❑ Bronchitis
- ❑ Tight sensation in chest
- ❑ Low immunity/catch cold easily

Head

- ❑ Headache or migraine
- ❑ Dizziness
- ❑ Fainting
- ❑ Eye strain
- ❑ Eye pain
- ❑ Blurred vision
- ❑ Spots or floaters in eyes
- ❑ Night blindness
- ❑ Nose bleeds
- ❑ Sores on lips/tongue
- ❑ Difficulty swallowing
- ❑ Ringing in ears
- ❑ Poor hearing
- ❑ Earache or infection
- ❑ Sinus pain/congestion
- ❑ Respiratory allergies
- ❑ Facial pain
- ❑ Dental or gum problems
- ❑ Grinding teeth
- ❑ Jaw clicks/locks

Digestive

- ❑ Nausea/Vomiting
- ❑ Gas
- ❑ Indigestion
- ❑ Bloating
- ❑ Tired after eating
- ❑ Peculiar tastes/smells
- ❑ Weight loss or gain
- ❑ Changes in appetite
- ❑ Excessive appetite
- ❑ Poor appetite
- ❑ Food cravings
- ❑ Strong thirst
- ❑ Acid reflux/heartburn
- ❑ Bad breath
- ❑ Diarrhea or loose stool
- ❑ Constipation
- ❑ Blood in stool
- ❑ Hemorrhoids
- ❑ Abdominal pain or cramping

Genital/Urinary

- ❑ Pain or burning with urination
- ❑ Unable to hold urine
- ❑ Night urination (more than 1 time per night)
- ❑ Frequent urination
- ❑ Urgent urination
- ❑ Blood in urine
- ❑ Dribbling after urination
- ❑ Urinary tract infection
- ❑ Low sexual desire
- ❑ Infertility
- ❑ Genital pain or itching

Neurological

- ❑ Seizures
- ❑ Vertigo/Dizziness
- ❑ Tremors
- ❑ Lack of coordination
- ❑ Loss of balance
- ❑ Difficulty with focus or concentration
- ❑ ADD/ADHD
- ❑ Areas of numbness
- ❑ Concussion
- ❑ Poor memory

Mental Health and Sleep

- ❑ Anxiety/Panic attacks
- ❑ Nervousness
- ❑ Depression
- ❑ Easily susceptible to stress
- ❑ Bipolar disorder
- ❑ Irritable/bad temper
- ❑ Worry or repetitive thinking
- ❑ Seasonal Affective Disorder
- ❑ Mood swings
- ❑ Insomnia/Poor sleep
- ❑ Sleep apnea

Musculoskeletal

Please note any areas of injury, pain, stiffness, or swelling:

- ❑ Neck
- ❑ Low Back
- ❑ Mid back
- ❑ Upper back
- ❑ Ankle
- ❑ Knee
- ❑ Hip
- ❑ Shoulder
- ❑ Wrist
- ❑ Elbow
- ❑ Other _____

Men Only

- ❑ Erectile dysfunction
- ❑ Premature ejaculation
- ❑ Nocturnal emission
- ❑ Pain in testicles
- ❑ Enlarged prostate

Women Only

- ❑ Irregular periods
- ❑ Painful periods
- ❑ Spotting between periods
- ❑ Heavy periods
- ❑ PMS
- ❑ Menopausal symptoms
- ❑ Ovarian cysts
- ❑ Endometriosis
- ❑ Uterine fibroids
- ❑ Polycystic breast tissue
- ❑ Breast pain
- ❑ Difficult/painful intercourse
- ❑ Vaginal dryness
- ❑ Vaginal discharge

Last menstrual period: _____

Age of first period: _____

Number of pregnancies: _____

Number of live births: _____

Do you use birth control? _____

What type? _____

How long? _____

Anything else you would like me to know?

_____

_____

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