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| **New Patient Health History** |
|  |  |  |  |  |  |  |  |  |  |  |
| **PATIENT INFORMATION** |  Today’s Date: |
| Patient’s Name: |  Gender: |  Date of Birth: |
| Alias/Maiden Name: | Preferred name: |
| Street Address: |
| Home Phone:  | Cell Phone: ( ) |
| Email Address: | May we send you emails about clinic events or newsletters? ☐ YES ☐ NO |
| ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Domestic partnership ☐ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  |  |  |  |  |  |  |  |  |  |  |
| **EMERGENCY CONTACT** |
| Emergency Contact: | Relationship: |
| Emergency Contact Phone: ( ) | Emergency Contact Office/Cell Phone: ( ) |
|  |  |  |  |  |  |  |  |  |  |  |
| **OTHER CARE PROVIDERS** |
|  Provider's Name: | Provider Type: |
|  Provider's Address: | Phone: |
|  Provider's Name: | Provider Type: |
|  Provider's Address: | Provider Type: |
|  |  |  |  |  |  |  |  |  |  |  |
| **EMPLOYMENT** |
| I am currently: ☐ Full-Time ☐ Part-time ☐ Self-employed ☐ Student ☐ Unemployed ☐ Retired |
| Job Title / Description: | Number of work/study hours per week: |
| **GENERAL HEALTH** |
| What is the primary concern associated with your visit today? |
| Onset: How long have you had this/these issues? |
| Does anything make the condition better? ☐ YES ☐ NO If yes, what? |
| Does anything make the condition worse? ☐YES ☐ NO If yes, what? |
| Have you been treated for this condition before? ☐ YES ☐ NO If yes, please describe. |
| Are you currently being treated for any other medical problems? ☐ YES ☐NO If yes, please describe. |
| Are there any other issues or health concerns you are hoping to work on? |
| Have you tried acupuncture before? ☐ YES ☐ NO If yes, please describe. |
| How did you hear about the clinic? ☐ Website ☐ Another Health Care Provider ☐ Advertisement ☐ Friend\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_ ☐ Other \_\_\_\_\_\_\_ \_\_\_\_\_\_\_  |
|  |  |  |  |  |  |  |  |  |  |  |
| **MEDICATIONS** |
| Do you have allergies to medications? ☐YES ☐NO If yes, please describe. |
| List any pharmaceuticals, both prescription and over the counter, that you are currently taking: |
| List all herbal prescriptions and supplements you are taking: |
| **DIET AND NUTRITION- Please describe your typical diet.** |
| Breakfast: |
| Lunch |
| Dinner |
| Snacks |
|  |  |  |  |  |  |  |  |  |  |  |
| **Risk Factors** |
| Are you currently using any of the following substances regularly, or have you used them in the past? |
| Substance | Current Usage  | Used in the past | Amount per day/week | Comments |
| Caffeine  | ☐ | ☐ |   |   |
| Tobacco  | ☐ | ☐ |   |   |
| Alcohol | ☐ | ☐ |   |   |
| Other  | ☐ | ☐ |   |   |
|  |  |  |  |  |  |  |  |  |  |  |
| **Health History** |
|  | **Self** | **Mother** | **Father** | **Sibling** | **Comments** |
| Allergies (environmental) | ☐ | ☐ | ☐ | ☐ |   |
| Anemia | ☐ | ☐ | ☐ | ☐ |   |
| Anxiety / Panic Attacks | ☐ | ☐ | ☐ | ☐ |   |
| Asthma | ☐ | ☐ | ☐ | ☐ |   |
| Autoimmune Disease | ☐ | ☐ | ☐ | ☐ |   |
| Bladder Disorder | ☐ | ☐ | ☐ | ☐ |   |
| Blood Disorder | ☐ | ☐ | ☐ | ☐ |   |
| Cancer | ☐ | ☐ | ☐ | ☐ |   |
| Constipation/Diarrhea | ☐ | ☐ | ☐ | ☐ |   |
| COPD/Emphysema | ☐ | ☐ | ☐ | ☐ |   |
| Depression | ☐ | ☐ | ☐ | ☐ |   |
| Diabetes (type I or type II) | ☐ | ☐ | ☐ | ☐ |   |
| Drug/ Alcohol Abuse | ☐ | ☐ | ☐ | ☐ |   |
| Headaches | ☐ | ☐ | ☐ | ☐ |   |
| Heart Attack | ☐ | ☐ | ☐ | ☐ |   |
| Heart Disease | ☐ | ☐ | ☐ | ☐ |   |
| Hepatitis | ☐ | ☐ | ☐ | ☐ |   |
| High Blood Pressure | ☐ | ☐ | ☐ | ☐ |   |
| High Cholesterol | ☐ | ☐ | ☐ | ☐ |   |
| Kidney Disorder | ☐ | ☐ | ☐ | ☐ |   |
| Migraines | ☐ | ☐ | ☐ | ☐ |   |
| Seizures | ☐ | ☐ | ☐ | ☐ |   |
| Sexually Transmitted Infection | ☐ | ☐ | ☐ | ☐ |   |
| Stomach/Intestinal Disorder | ☐ | ☐ | ☐ | ☐ |   |
| Stroke | ☐ | ☐ | ☐ | ☐ |   |
| Thyroid Disorder | ☐ | ☐ | ☐ | ☐ |   |
|  |  |  |  |  |  |  |  |  |  |  |
| **Signs and Symptoms** (check if currently experiencing the issue or have experienced it in the past) |
| **General Symptoms** |  | **Head and Neck Symptoms** |  |  |
|   | Current | Past |  |   | Current | Past |  |  |
| Anxiety/Mood swings | ☐ | ☐ |  | Headaches | ☐ | ☐ |  |  |
| Chills | ☐ | ☐ |  | Migraines | ☐ | ☐ |  |  |
| Cold hands/feet | ☐ | ☐ |  | Stiff neck | ☐ | ☐ |  |  |
| Crave bitter foods | ☐ | ☐ |  | Dizziness | ☐ | ☐ |  |  |
| Crave salty foods | ☐ | ☐ |  | Fainting | ☐ | ☐ |  |  |
| Crave sour foods | ☐ | ☐ |  | Swollen glands | ☐ | ☐ |  |  |
| Crave spicy foods | ☐ | ☐ |  |  |  |  |  |  |  |
| Crave sweets  | ☐ | ☐ |  | **Ear Symptoms** |  |  |
| Decreased smell | ☐ | ☐ |  |   | Current | Past |  |  |
| Decreased taste  | ☐ | ☐ |  | Ear ringing | ☐ | ☐ |  |  |
| Depression | ☐ | ☐ |  | Hearing loss | ☐ | ☐ |  |  |
| Dreams/nightmares | ☐ | ☐ |  | Infections | ☐ | ☐ |  |  |
| Fatigue | ☐ | ☐ |  | Earache | ☐ | ☐ |  |  |
| Fever | ☐ | ☐ |  | Vertigo | ☐ | ☐ |  |  |
| Insomnia | ☐ | ☐ |  |  |  |  |  |  |  |
| Irritability | ☐ | ☐ |  | **Nose/Throat Symptoms** |  |  |
| Night sweats | ☐ | ☐ |  |   | Current | Past |  |  |
| Often feel afraid | ☐ | ☐ |  | Sinus infections | ☐ | ☐ |  |  |
| Often feel angry  | ☐ | ☐ |  | Allergies | ☐ | ☐ |  |  |
| Often feel sad  | ☐ | ☐ |  | Dry throat | ☐ | ☐ |  |  |
| Often indecisive | ☐ | ☐ |  | Sore throat | ☐ | ☐ |  |  |
| Often worried  | ☐ | ☐ |  | Difficulty swallowing | ☐ | ☐ |  |  |
| Poor memory | ☐ | ☐ |  | Bad breath | ☐ | ☐ |  |  |
|  |  |  |  |  | Bleeding gums | ☐ | ☐ |  |  |
| **Neurological Symptoms** |  | Grinding teeth | ☐ | ☐ |  |  |
|   | Current | Past |  | Nasal congestion | ☐ | ☐ |  |  |
| Seizures | ☐ | ☐ |  | Nosebleeds | ☐ | ☐ |  |  |
| Tremors | ☐ | ☐ |  | Loss of voice | ☐ | ☐ |  |  |
| Numbness/Tingling | ☐ | ☐ |  |  |  |  |  |  |  |
| Paralysis | ☐ | ☐ |  | **Skin Symptoms** |  |  |
|  |  |  |  |  |   | Current | Past |  |  |
| **Eye Symptoms** |  | Hives | ☐ | ☐ |  |  |
|   | Current | Past |  | Rashes | ☐ | ☐ |  |  |
| Corrective lenses | ☐ | ☐ |  | Eczema/Psoriasis | ☐ | ☐ |  |  |
| Blurred vision | ☐ | ☐ |  | Dry skin | ☐ | ☐ |  |  |
| Poor night vision | ☐ | ☐ |  | Easy bruising | ☐ | ☐ |  |  |
| Spots or floaters | ☐ | ☐ |  | Changes in moles | ☐ | ☐ |  |  |
| Eye inflammation | ☐ | ☐ |  | Itching | ☐ | ☐ |  |  |
| Dryness | ☐ | ☐ |  | Measles | ☐ | ☐ |  |  |
| Tearing | ☐ | ☐ |  | Chickenpox | ☐ | ☐ |  |  |
| Glaucoma | ☐ | ☐ |  | Shingles | ☐ | ☐ |  |  |
| Cataracts | ☐ | ☐ |  | Acne | ☐ | ☐ |  |  |
| **Signs and Symptoms Continued** |
| **Respiratory Symptoms** |  | **Musculoskeletal Symptoms** |  |  |
|   | Current | Past |  |   | Current | Past |  |  |
| Difficulty breathing | ☐ | ☐ |  | Joint pain | ☐ | ☐ |  |  |
| Wheezing | ☐ | ☐ |  | Weak muscles  | ☐ | ☐ |  |  |
| Asthma | ☐ | ☐ |  | Sore/weak knees | ☐ | ☐ |  |  |
| Chronic cough | ☐ | ☐ |  | Sore/weak ankles | ☐ | ☐ |  |  |
| Wet cough | ☐ | ☐ |  | Difficulty walking | ☐ | ☐ |  |  |
| Cough with phlegm | ☐ | ☐ |  | Neck/shoulder pain | ☐ | ☐ |  |  |
| Cough with blood | ☐ | ☐ |  | Upper/mid back pain | ☐ | ☐ |  |  |
|  |  |  |  |  | Lower back pain | ☐ | ☐ |  |  |
| **Cardiovascular Symptoms** |  | Rib pain | ☐ | ☐ |  |  |
|   | Current | Past |  | Limited motion | ☐ | ☐ |  |  |
| High blood pressure | ☐ | ☐ |  | Muscle spasms | ☐ | ☐ |  |  |
| Low blood pressure | ☐ | ☐ |  |  |  |  |  |  |  |
| Chest pain or tightness | ☐ | ☐ |  | **Genito-Urinary Symptoms** |  |  |
| Palpitations  | ☐ | ☐ |  |   | Current | Past |  |  |
| Rapid heartbeat | ☐ | ☐ |  | Frequent urination | ☐ | ☐ |  |  |
| Poor circulation | ☐ | ☐ |  | Painful urination  | ☐ | ☐ |  |  |
| Swollen ankles | ☐ | ☐ |  | Urgent urination | ☐ | ☐ |  |  |
| Anemia | ☐ | ☐ |  | Blood in urine | ☐ | ☐ |  |  |
|  |  |  |  |  | Incomplete urination  | ☐ | ☐ |  |  |
| **Gastrointestinal Symptoms** |  | Bedwetting | ☐ | ☐ |  |  |
|   | Current | Past |  | Wake to urinate | ☐ | ☐ |  |  |
| Nausea | ☐ | ☐ |  | Kidney stone | ☐ | ☐ |  |  |
| Vomiting | ☐ | ☐ |  | Increased sex drive | ☐ | ☐ |  |  |
| Acid reflux/GERD  | ☐ | ☐ |  | Decreased sex drive | ☐ | ☐ |  |  |
| Stomach pain  | ☐ | ☐ |  | Genital pain/itching | ☐ | ☐ |  |  |
| Abdominal bloating | ☐ | ☐ |  | Genital lesions | ☐ | ☐ |  |  |
| Indigestion | ☐ | ☐ |  | Genital discharge | ☐ | ☐ |  |  |
| Poor appetite | ☐ | ☐ |  | Infertility | ☐ | ☐ |  |  |
| Change in appetite | ☐ | ☐ |  |  |  |  |  |  |  |
| Gas: Belching | ☐ | ☐ |  | **Female Specific Symptoms** |  |
| Gas: Flatulence | ☐ | ☐ |  |   | Current | Past |  |
| Diarrhea | ☐ | ☐ |  | Frequent urinary tract infections | ☐ | ☐ |  |
| Constipation  | ☐ | ☐ |  | Frequent vaginal infections | ☐ | ☐ |  |
| Dry/hard stool | ☐ | ☐ |  | Pelvic inflammatory disease | ☐ | ☐ |  |
| Blood in stool | ☐ | ☐ |  | Abnormal PAP smear | ☐ | ☐ |  |
| Hemorrhoids | ☐ | ☐ |  | Irregular periods | ☐ | ☐ |  |
| Jaundice | ☐ | ☐ |  | Premenstrual syndrome | ☐ | ☐ |  |
| Liver disorder | ☐ | ☐ |  | Painful menstrual bleeding | ☐ | ☐ |  |
| Gall bladder disorder | ☐ | ☐ |  | Abnormal bleeding | ☐ | ☐ |  |
|  |  |  |  |  | Menopause symptoms | ☐ | ☐ |  |
|  |  |  |  |  | Breast lumps | ☐ | ☐ |  |
|  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  | **Male Specific Symptoms** |  |
|  |  |  |  |  |   | Current | Past |  |
|  |  |  |  |  | Premature ejaculation | ☐ | ☐ |  |
|  |  |  |  |  | Testicular lumps | ☐ | ☐ |  |
|  |  |  |  |  | Prostatitis | ☐ | ☐ |  |
|  |  |  |  |  | Impotence | ☐ | ☐ |  |
|  |  |  |  |  |  |  |  |  |  |  |
| FEMALE REPRODUCTIVE HEALTH |
| Age of first menstruation | First day of last menses: | Duration of flow (# of days): | Clots: (yes, no) |
| Color of Blood: | Number of days in cycle (21, 28, 33, etc.): | Consistency (thin, thick): |
| PMS:  | Cramps | Pain | Breast Tenderness | Other |   |
|   | ☐ | ☐ | ☐ | ☐ |
| Current method of contraception: | Contraception History: |
| Have you ever been pregnant? Yes/No | Are you currently pregnant? yes no | Due Date: |
| Date of menopause: | Hormone Replacement Therapy? Yes/No | **I understand that I must notify my practitioner if I become pregnant** |
|
|  |  |  |  |  |  |  |  |  |  |  |
| PRIOR HOSPITALIZATIONS OR SURGERIES |
| Year: | Operation/Condition: |   |
| Year: | Operation/Condition: |   |
| Year: | Operation/Condition: |   |
|  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |
| Please provide any additional information you feel would be helpful |
|   |