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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
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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 | | | | | | | | | | |
|  | | | | | | | | | | |