In Hand Acupuncture and Herbs

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HEALTH HISTORY FORM

Please help us provide a complete evaluation for you by taking the time to fill out this form carefully. The information you provide will be held absolutely confidential. If there is anything you wish to bring to our attention, which is not asked on this form, please note it in the "**Comments**" section. Thank you!!

First Name:			Last Name:
Gender: ☐F ☐M	DOB: / /		Home Phone:
Address:			Work Phone:
City	State	Zip	Cell Phone:
Occupation:	Employer:		E-mail:
Height:	Weight:		Marital Status: ☐M ☐S ☐D ☐W
Emergency Contact (Include Name, Relationship & Phone) :			
Family Physician:			Insurance Company & Policy Number:
How did you learn about our clinic? ☐Doctor's Referral ☐Friend ☐Website ☐Event ☐Business ☐Other:			
Please let us know if someone referred you so we can thank them! Referred by:			

Main Health Concern(s)	How long ago did this begin?	Any given diagnosis	Any treatment you have tired
1st			
2nd			
3rd			
Have you ever treated by oriental medicine (including acupuncture, herbs, etc.)? ☐Yes ☐No			

Past Medical History — Please mark what applicable to you from the past to the present.

☐AIDS/HIV ☐Alcoholism ☐Anemia ☐Asthma ☐Auto-immune Disease ☐Cancer
☐Diabetes ☐Eye problems ☐Heart Disease ☐Hepatitis ☐High Blood Pressure ☐Herpes
☐Kidney Disease ☐Mental Illness ☐Osteoporosis ☐Rheumatic Fever ☐Seizure ☐Stroke
☐STD ☐Thyroid ☐Tuberculosis ☐Others:

Surgeries:

Significant Trauma (auto accidents, injuries, etc.):

Allergies (chemicals, drugs, foods, etc.) :

FAMILY Medical History (including your parents and siblings)

☐Anemia ☐Asthma ☐Auto-immune Disease ☐Cancer ☐Diabetes ☐Heart Disease
☐Hepatitis ☐High Blood Pressure ☐Mental Illness ☐Seizure ☐Stroke ☐Others:

Medicines taken within the last 2 months (drugs, vitamins, herbs, etc.):

Occupational stress (chemical, physical, psychological, etc.):

Do you have a regular exercise program? If yes, please describe it.

Please describe your average daily diet.

Morning:	Afternoon:	Evening:

Have you ever been a restricted diet? If yes, what kind?

How many ounce of water do you drink per day?

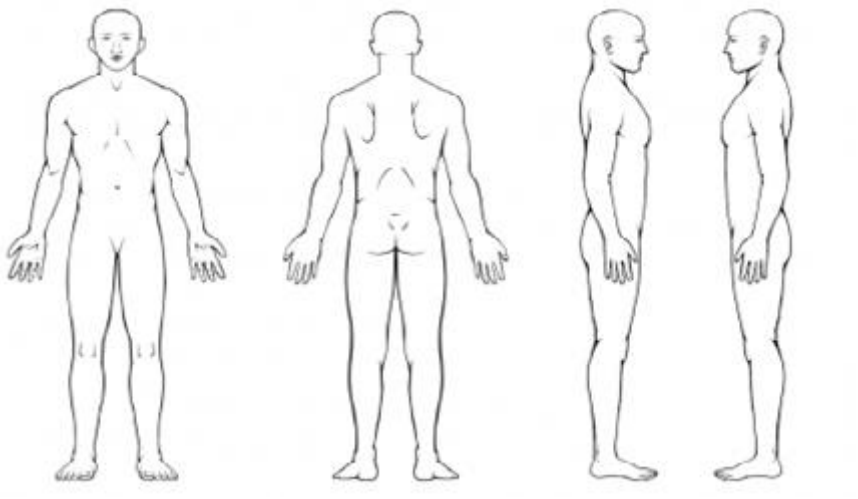
Do you smoke? If yes, how much per day (week)?

How much caffeinated coffee, tea, or cola do you drink per day?

How much alcoholic drink/beverages do you drink per day?

Please describe any use of drugs for non-medical purpose:

Please Indicate Any Areas of Pain



Please Check If You Have Had (In The Last 3 Months)

General

☐Fever	☐Poor Sleep	☐Chills	☐Sweat Easily
☐Cravings	☐Night Sweats	☐Fatigue	☐Strange Tastes or Smells
☐Hair Loss	☐Strong thirst	☐Hot flashes	☐Weight Loss/Gain
☐Bruise easily	☐Sudden Energy Drop (what time of day?)		☐Other

Head, Eyes, Ears, Nose & Throat

☐Dizziness	☐Vertigo	☐Migraines	☐Poor Concentration
☐TMJ	☐Teeth Grinding	☐Sinus Congestion	☐Running Nose
☐Nose Bleed	☐Poor Vision	☐Red/Itchy Eyes	☐Cataracts
☐Floaters	☐Color Blindness	☐Night Blindness	☐Spots in front of eyes
☐Bleeding Gums	☐Cold Sores	☐Sore Throat	☐Bad breath
☐Toothache	☐Earache	☐Poor Hearing	☐Ringing in Ears
☐Headache (Where, When?)			☐Other

Skin & Hair

☐Rashes	☐Itching	☐Ulcerations	☐Loss of Hair
☐Eczema	☐Pimples	☐Hives	☐Change in Hair/Skin Texture
☐Dandruff	☐Other		

Respiratory

☐Persistent cough ☐Chest congestion ☐Chest tightness ☐Nosebleeds

☐Chronic allergies ☐Sneezing ☐Wheezing ☐Shortness of breath

☐Frequent colds/flu ☐Other

Gastrointestinal

☐Indigestion ☐Gas ☐Stomach ache ☐Gurgling in intestines

☐Nausea ☐Vomiting ☐Acid reflux ☐Abdominal Fullness

☐Belching ☐Heartburn ☐Hiccups ☐Diarrhea

☐Loose stools ☐Constipation ☐Hemorrhoids ☐Mucous in stools

☐Blood in stools How many BM daily:___ ☐Other problem

Cardiovascular

☐Chest Pain ☐Fainting ☐Low Blood Pressure ☐High Blood Pressure

☐Phlebitis ☐Blood Clots ☐Irregular Heartbeat ☐Cold Hands and Feet

☐Swelling of Feet ☐Swelling of Hands ☐Difficult Breath ☐Other:_____

Female Health

Age of 1st Menses:____ First day of last period: ____ Cycle length:____ Period length:_____

☐Irregular Periods ☐Menstrual Pain ☐Menstrual Clots ☐Menopause (age____)

# of pregnancy: _____ # of live birth:_____ # of miscarriage: ___ # of Abortion: ____

Are you currently using birth control? ☐Y ☐N If yes, what type and for how long? _____

Neuropsychological

☐Nausea ☐Loss of Balance ☐Poor Memory ☐Areas of Numbness

☐Depression ☐Anxiety ☐Tremors ☐Other

Have you ever been treated for emotional problems? (when & what?)

Comments *Please tell us any other concerns you would like to discuss.*

_____

_____