NATUREMED ACUPUNCTURE
Medical Massage • Herbal Medicine

Acupuncture Client Health History

Please help us provide you with a complete evaluation by taking the time to fill out this questionnaire carefully. All of your answers will be held absolutely confidential. If you have questions, please ask. If there is anything you wish to bring to our attention that is not asked on this form, please note it in the comments section. Thank You.

Name _____ Date _____

Name of Client's Representative (if applicable) _____

Address _____ City/State/Zip _____

Phone: Cell _____ Home _____

Email _____ Occupation _____

Emergency Contact Name/Phone _____

Date of Birth _____ Referred By _____

Physician _____ Phone/Address _____

Main problem you would like to address:

To what extent does this problem affect your daily activities (work, sleep, eating, etc.)

When did you first notice symptoms?

Have you been given a diagnosis for the problem by your physician? Y ___ N ___ If yes, please describe:

Have you tried acupuncture or Chinese herbal medicine before? When, Why?

Past Medical History

☐Allergies	☐Accidents/Trauma	☐Cancer
☐Diabetes	☐Hepatitis	☐Heart disease
☐High blood pressure	☐Rheumatic fever	☐Seizures
☐STD	☐Thyroid disease	☐HIV

Please elaborate on checked boxes, including dates:

_____

_____

_____

Family Medical History

Please indicate any significant family medical history:

_____

_____

Lifestyle

Do you exercise regularly? Y ____ N ____ If yes, please describe

_____

_____

Describe your average daily diet:

Usual breakfast choices, time eaten

Usual lunch choices, time eaten

Usual dinner choices, time eaten

Usual snack choices, time eaten

Coffee, tea – how much, how often

Alcohol – how much, how often

Do you now or have you ever smoked? Y ____ N ____ How much, how often?

Medications taken within the last two months (include vitamins, herbs, over-the-counter medications, etc.)

Current and Recent Health Conditions

Please put a check next to the conditions you have experience within the **last three (3) months**. Indicate the length of time you have had this condition, or how long it lasted.

General

☐Bleeding or bruising	☐Strong thirst	☐Disturbed sleep	☐Fever or Chills
☐Weight gain/loss	☐Insomnia	☐Sweat easily	☐Sudden energy drop
☐Localized weakness	☐Night sweats	☐Poor balance	

Please elaborate on the checked boxes:

_____

_____

Musculoskeletal

☐Neck pain	☐Back pain	☐Foot, ankle pain	☐Other
☐Hand, wrist pain	☐Knee pain	☐Muscle pain	_____
☐Shoulder pain	☐Hip pain	☐Muscle weakness	

Please elaborate on the checked boxes:

_____

_____

Head, Eyes, Ears, Nose and Throat

☐Headaches	☐Sores on lips/tongue	☐ Poor vision	☐Eye strain
☐Migraines	☐Jaw clicks	☐Glasses	☐Spots in front of eyes
☐Concussion	☐Tooth problems	☐Cataracts	☐Poor hearing
☐Facial pain	☐Grinding teeth	☐Color blindness	☐Earaches
☐Sinus problems	☐Recurrent sore throat	☐Night blindness	☐Ringing in ears
☐Nose bleeds	☐Blurry vision	☐Eye pain	☐Other _____

Please elaborate on the checked boxes:

_____

_____

Cardiovascular

☐Chest pain	☐Fainting	☐Blood clots
☐High blood pressure	☐Swelling of the hands/feet	☐Cold hands or feet
☐Difficulty breathing	☐Low blood pressure	

Please elaborate on the checked boxes:

_____

_____

Respiratory

☐Asthma ☐Bronchitis ☐COPD/emphysema
☐Cough ☐Coughing up blood ☐Difficulty breathing lying down
☐Frequent colds ☐Pain with deep breath ☐Other _____
☐Production of phlegm ☐Pneumonia

Please elaborate on the checked boxes:

_____

_____

Gastrointestinal

☐Abdominal pain or cramps ☐Belching ☐Constipation
☐GERD ☐Nausea ☐Hemorrhoids
☐Indigestion ☐Changes in appetite ☐Blood in stool
☐Poor appetite ☐Vomiting ☐Rectal pain
☐Gas ☐Diarrhea

Please elaborate on the checked boxes:

_____

_____

Neuropsychological

☐Anxiety ☐Stress easily ☐Concussion ☐Lack of coordination
☐Depression ☐Areas of numbness ☐Seizures ☐Loss of balance
☐Bad temper ☐Poor memory ☐Dizziness ☐Tremors

Have you ever been treated for emotions problems? If yes, please describe below

Please elaborate on the checked boxes:

_____

_____

Skin and Hair

☐Acne/pimples ☐Hives ☐Itching ☐Changes in hair or skin
☐Rashes ☐Eczema ☐Dandruff texture
☐Ulcerations ☐Recent moles ☐Hair loss ☐Other _____

Please elaborate on the checked boxes:

_____

_____

Female Reproductive and Gynecologic

☐Heavy period	☐Menstrual clots	☐Breast tenderness	☐Irregular or unusual periods
☐Light period	☐Infertility	☐Vaginal dryness	
☐Fibroids	☐Endometriosis	☐Bleeding during, after sex	
☐Painful periods	☐ Vaginal discharge		

Do you use birth control? Y ____ N ____ If so, what type and how long?
Age of first period _____ Time between periods _____ Duration _____
First day of last period _____
Number of pregnancies _____ Number of births _____ Premature births, miscarriages Y ____ N ____
Menopause? If yes, at what age _____

Please elaborate on the checked boxes:

_____

_____

Male Reproductive

☐Prostate Cancer	☐Erectile dysfunction	☐Frequent urination
☐Painful urination	☐Difficulty urinating	☐Premature ejaculation

Please elaborate on the checked boxes:

_____

_____

Genito-urinary

☐Frequent urination	☐Unable to hold urine	☐Kidney stones	☐Other _____
☐Urgency to urinate	☐Blood in urine	☐Impotence	
☐Pain during urination	☐Decrease in flow	☐Sores on genitals	

Do you wake at night to urinate? If so, how often?

Please elaborate on the checked boxes:

_____

_____

Pain, Stress and Tension Areas

On the figures to the right, indicate the areas where you carry tension, experience discomfort, or hold stress.

On a scale of 0 (no stress) to 10 (high levels of stress) please indicate the amount of stress in your life ____

Any additional information, comments

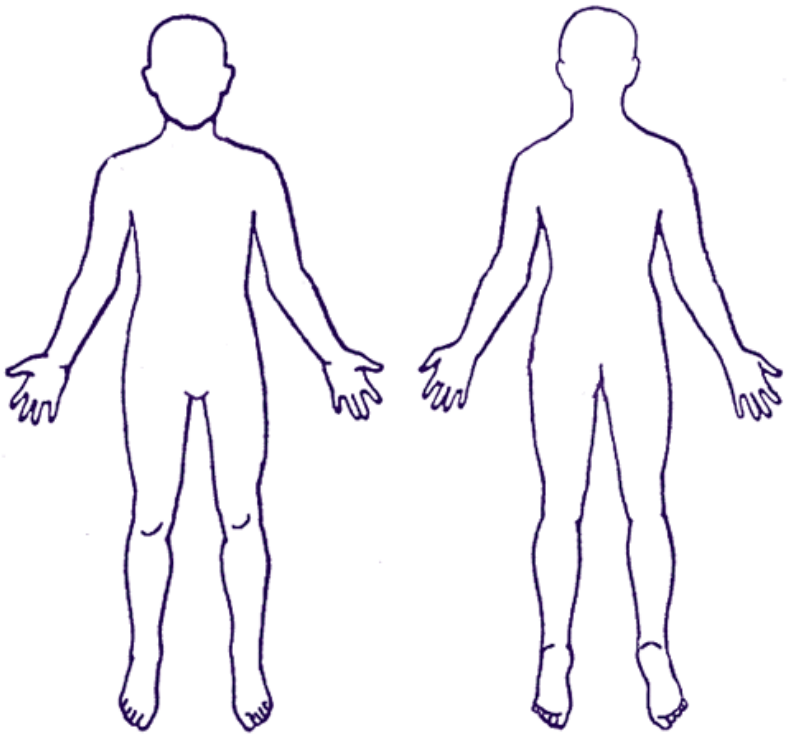
_____

_____

_____

_____

_____



All of the information is correct and current to the best of my knowledge and I will update my health history form with any changes in my health and medication.

_____ _____

Patient Name Date

_____

Signature – Patient or Representative *(include relationship if signing for patient)*