

Health History Questionnaire

Information for your Acupuncturist

Important: Complete this document as thoroughly as possible. Some of the questions that follow may seem unrelated to your condition, but they may play a major role in diagnosis and treatment.

All information is strictly confidential

Your General Information (Please print)

Date: _____/_____/_____ Name: _____

Address: _____ City _____

State: _____ Zip code _____ Cell Phone: (_____) _____ - _____

Home Phone: (_____) _____ - _____ Work Phone: (_____) _____ - _____

Email: _____ Allow us e-mail contact Yes No

Age: _____ Date of Birth _____/_____/_____ Place of Birth _____

Occupation _____ Guardian (if under 18): _____

Gender: Male Female Height: _____' _____" Weight: _____ lbs.

Does anything limit you from care? Yes No If yes, reason/s why: _____

Have you done acupuncture before: Yes No. (If yes, about how many times: _____)

How did you hear about our office: Referral by: _____

Google CitySearch Other _____

Your Purpose and Goal for visiting me today:

1. _____

2. _____

3. _____

4. _____

5. _____

Conditions you want to improve

Severe Moderate Slight

1	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
2	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
3	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
4	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
5	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
6	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
7	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Other conditions you want to improve: _____

How do these conditions impair your daily activities? _____

Other Physicians/therapists are seeing

Dr. _____ For _____

Dr. _____ For _____

Dr. _____ For _____

Medications you are taking:

Medications: _____ Prescribed by _____ For: _____

Medications: _____ Prescribed by _____ For: _____

Medications: _____ Prescribed by _____ For: _____

Medications: _____ Prescribed by _____ For: _____

Medications: _____ Prescribed by _____ For: _____

Supplements (if any vitamins, herbs, minerals, etc.):

Please check the following that pertain to you:

Energy level:	High	Medium	Low	
Appetite:	High	Normal	Low	
Stress level:	High	Medium	Low	
Sleep:	Good	OK	Poor	
Bowel Movement:	Constipation	Normal	Loose	Diarrhea
Emotion:	Anxiety	Anger	Fear	Sadness
	Worry	Other:	_____	

Urination: Frequency _____ Color _____ Other _____

Recent tests: (please indicate test results and date below)

Physical Cholesterol Prostate Blood (which?) HIV/STD
 Pap Smear Mammography Other: _____

Your Medical History

How was your childhood health? _____

Hospital Visits / Stays: _____

Check any you have had in the past:

- Diabetes allergies glaucoma Rheumatic Fever
- Polio Stroke Vein condition Thyroid disorder
- Asthma Pneumonia Tuberculosis Emphysema
- Jaundice Gonorrhea Mumps Bleeding tendency
- Syphilis Measles Chicken pox Nervous disorder
- Epilepsy HIV Heart disease Mononucleosis
- Paralysis Cancer Migraines High blood pressure
- Meningitis High fever Hepatitis Multiple Sclerosis
- other lung illnesses other liver illnesses other heart illnesses
- other kidney illnesses other spleen illnesses other stomach illnesses

other: _____

Immunization: _____

Surgeries: _____

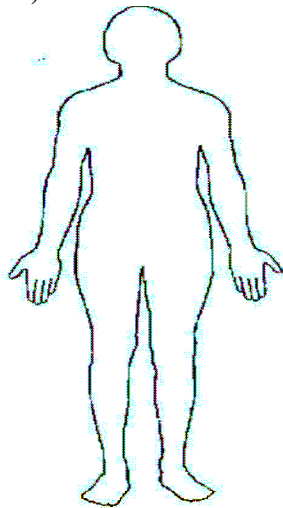
Your Family History

Family member	Alive	Deceased	present health or cause of death
Father	<input type="checkbox"/>	<input type="checkbox"/>	_____
Mother	<input type="checkbox"/>	<input type="checkbox"/>	_____
Spouse	<input type="checkbox"/>	<input type="checkbox"/>	_____
Children	<input type="checkbox"/>	<input type="checkbox"/>	_____
Brother	<input type="checkbox"/>	<input type="checkbox"/>	_____
Brother	<input type="checkbox"/>	<input type="checkbox"/>	_____
Sister	<input type="checkbox"/>	<input type="checkbox"/>	_____
Sister	<input type="checkbox"/>	<input type="checkbox"/>	_____
Sister	<input type="checkbox"/>	<input type="checkbox"/>	_____

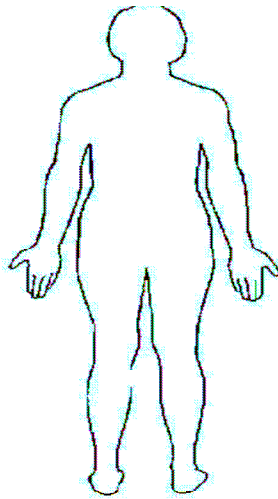
Where are you in the birth order? First last middle only Other_____

Patient Profile

Please clearly mark any areas of pain and any scars (please indicate which of the area are scars):



Front



Back

Is the pain: Sharp Burning Aching Cramping Dull Moving Fixed Other:_____

Do the following lessen the pain: Pressure Cold Heat Exercise Other:_____

Do the following worsen the pain: Pressure Cold Heat Other:_____

Women's Health (Gentleman, go to bottom of this page.)

Pregnant Yes No

Age of first menstruation:___ / Number of days of flow___

Cycle: every _____days / Vaginal discharge_____

Fertility challenge:_____

Irregular Period_____ Fibroids_____

Endometriosis _____ Ovarian cysts_____

Others_____

Number of pregnancies___ Number of Birth __ Miscarriage__

Any of the following pre-menstrual syndromes:

- | | | |
|-------------------|---------------|-----------------|
| Vomiting | Nausea | Headaches |
| Anxiety | Food cravings | Irritability |
| Breast swelling | Depression | Water retention |
| Breast tenderness | Migraines | |

Please fill in the following menstrual chart:

	Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7
Color (normal, bright red, pale, brown, rust, dark, purple, other)							
Amount of flow (normal, heavy, light)							
Pain / cramps (location, dull, sharp, other)							
Clots (large, small, black, purple, red, other)							
Other							

Age of Menopause (if applicable)_____ Hot flashes___

Night sweats_____ Dry skin _____ Other_____

Patient signature: _____ **Date:**_____

Dear patient, please fill and sign this form. Thanks you!

Acupuncture Plus
Notification Form Regarding
Evaluation of Patient by Physician



(Pursuant to the requirement of Section 6.11, Subsection (b) through (d) V.A.C.S., article 4495b, governing the practice of acupuncture)

I _____ am
notifying Acupuncture Plus of the following:

Yes_____ No_____ I have been evaluated by a physician, dentist or nurse practitioner for the condition being treated within six months before the acupuncture was performed.

I recognize I should be evaluated by a physician for the condition being treated by the acupuncturist.

OR

Yes_____ No_____ I have received a referral from a chiropractor within the last 30 days for acupuncture. After being referred by a chiropractor, if after 30 days or 20 treatments, whichever comes first, no substantial improvement occurs in the condition being treated, I understand that the acupuncturist is required to refer me to a physician.

It is my responsibility and choice to follow this advice.

Patient signature (required)

Date

*Acupuncture Plus is not responsible for
untrue statements made by patients.*