

Tri-Cities Acupuncture & Wellness  
Patient Health History

*Successful health care and preventative medicine are only possible when the practitioner has a complete understanding of the patient physically, mentally and emotionally. Even if some questions seem unrelated to your current condition, please answer this questionnaire as thoroughly as possible. Please print clearly, and mark any areas of confusion with a question mark. Thank you.*

**All information is strictly confidential.**

Name \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Place of Birth \_\_\_\_\_ Age \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone Number (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Cell Phone Number (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Email Address \_\_\_\_\_

Emergency Contact Person \_\_\_\_\_

Emergency Contact Phone Number(s) (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ or (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Primary Care Physician \_\_\_\_\_

Approx. Date of Last Visit \_\_\_\_\_ Physician's Office Phone Number (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

How did you hear about Tri-Cities Acupuncture & Wellness? \_\_\_\_\_

Have you ever had acupuncture before? Yes / No

What is the main reason for your appointment today? \_\_\_\_\_

How long have you been experiencing this problem? \_\_\_\_\_

What makes this condition worse? \_\_\_\_\_

What makes this condition better? \_\_\_\_\_

What other treatments have you tried for this condition? \_\_\_\_\_

What would you like to achieve from treatment?
1.
2.
3.

Please list any other health concerns in order of importance:
1.
2.
3.

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**Medical History**

**Height:** \_\_\_\_\_ft.\_\_\_\_\_in. **Weight:** \_\_\_\_\_ **Cholesterol:** \_\_\_\_\_  
**Blood Pressure:** Most recent reading \_\_\_\_\_/\_\_\_\_\_ When was this taken? \_\_\_\_\_

**Please answer the following questions:**

- Yes / No I have a pacemaker  
Yes / No I am currently being treated with blood thinners or anti-clotting medications  
Yes / No I am prone to excessive bleeding and/or poor wound healing  
Yes / No I have a medical condition that may cause my liver, spleen, heart or lungs to be enlarged

**Childhood Illness (please check all you have had):**

- Scarlet Fever Mumps German Measles  
Rheumatic Fever Measles Chicken Pox

**Immunizations (please check all you have had):**

- Polio Measles/Mumps/Rubella HPV (Cervical Cancer)  
Tetanus Diphtheria Varicella (Chicken Pox)  
Pertussis Hepatitis B Influenza (Flu)

**Have you been diagnosed with any of these conditions? Check all that apply.**

- AIDS/HIV Endocrine Disorder Lyme's Disease  
Alcoholism Epilepsy Multiple Sclerosis  
Artery disease Fibromyalgia Polio  
Asthma Gout Rheumatic Fever  
Birth trauma Heart Disease Scarlet Fever  
Cancer Hepatitis A / B / C Seasonal Allergies  
Diabetes Herpes Seizures  
Drug Addiction High blood pressure Tuberculosis  
Emphysema Joint Replacement(s) Thyroid Disorder

**Have you suffered any major traumas, physical or emotional? \_\_\_\_ If yes, please describe:**

\_\_\_\_\_

**Hospitalizations and Surgeries**

<u>Reason</u>	<u>Date</u>	<u>Reason</u>	<u>Date</u>
_____	_____	_____	_____
_____	_____	_____	_____

**Please list any known allergies (environmental, latex, food, medications, stings, etc.)**

<u>Allergen</u>	<u>Reaction</u>	<u>Allergen</u>	<u>Reaction</u>
_____	_____	_____	_____
_____	_____	_____	_____

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**List your current Medications, Vitamins & Supplements:** (use the back of page if needed)

Medication/ Supplement	Dosage	For what purpose/condition?

**Family Health History:** Check all that apply to your Mother, Father, Siblings and Children:

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Alzheimer's           | <input type="checkbox"/> Drug Abuse/ Alcoholism | <input type="checkbox"/> Musculoskeletal Disorder |
| <input type="checkbox"/> Autoimmune Disease    | <input type="checkbox"/> Heart Disease          | <input type="checkbox"/> Parkinson's Disease      |
| <input type="checkbox"/> Cancer                | <input type="checkbox"/> Kidney Disease         | <input type="checkbox"/> Stroke                   |
| <input type="checkbox"/> Cholesterol, Elevated | <input type="checkbox"/> Liver Disease          | <input type="checkbox"/> Seizures                 |
| <input type="checkbox"/> Depression            | <input type="checkbox"/> Mental Illness         | <input type="checkbox"/> Thyroid Disorder         |
| <input type="checkbox"/> Diabetes              | <input type="checkbox"/> Multiple Sclerosis     |   |

**Energy & Sleep**

How is your energy? \_\_\_\_\_ Do you fatigue easily? \_\_\_\_\_  
 When is your energy highest? \_\_\_\_\_ Lowest? \_\_\_\_\_  
 How long do you normally sleep? \_\_\_\_\_ hours per night. Do you wake feeling rested? \_\_\_\_\_  
 Do you have difficulties with any of the following (check all that apply):  
 Falling asleep                       Dream disturbed sleep                       Restless leg  
 Staying asleep                       Snoring                       Mind racing at night  
 Do you wake at a certain time of night? \_\_\_\_\_ If yes, when? \_\_\_\_\_

**Emotions & Stress**

Depression             Over-thinking             Poor concentration             Anxiety             Nervousness  
 Fear                       Panic attacks             Poor memory                       Irritable             Short temper  
 How do you hold stress? \_\_\_\_\_  
 How do you relax? \_\_\_\_\_  
 What is your occupation? \_\_\_\_\_  
 How do you feel about your work? \_\_\_\_\_  
 What kind of exercise do you do? \_\_\_\_\_ How often? \_\_\_\_\_

**Eating Habits:** Please describe your current eating habits:

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Low-carbohydrate diet | <input type="checkbox"/> Vegetarian                 | <input type="checkbox"/> Eat a lot of fried food |
| <input type="checkbox"/> Low-fat diet          | <input type="checkbox"/> Eat a lot of dairy         | <input type="checkbox"/> Eat a lot of red meat   |
| <input type="checkbox"/> Vegan                 | <input type="checkbox"/> Eat a lot of carbohydrates | <input type="checkbox"/> Eat a lot of sweets     |
- Do you place any restrictions on your diet? \_\_\_\_\_ If yes, please explain \_\_\_\_\_

How do you perceive your current weight? Underweight/ Normal/ Slightly overweight/ Overweight

**Tobacco/ Alcohol Use**

- Smoke tobacco, # of packs per day: \_\_\_\_\_  Quit smoking \_\_\_\_\_ months/years ago  
 Drink alcohol, # of drinks per week: \_\_\_\_\_  Quit drinking \_\_\_\_\_ months/years ago

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Please write "C" next to symptoms you currently experience, and "P" next to symptoms you have experienced in the past year.

**General**

- Prefer cold drinks
- Prefer hot drinks
- Recent weight loss or gain
- Cold hands & feet
- Chills
- Fever or sensation of heat
- Frequent colds

**Head & Neck**

- Headaches/ Migraines
- Stiff neck
- Dizziness
- Fainting
- Swollen glands

**Ears**

- Ringing
- Hearing loss
- Frequent Ear Infections
- Earache

**Eyes**

- Glasses/ contacts
- Blurred vision
- Poor night vision
- Spots or floaters
- Eye inflammation
- Double vision
- Glaucoma
- Cataracts

**Nose, Throat & Mouth**

- Sinus infection
- Hay fever/ allergies
- Frequent sore throat
- Difficulty swallowing
- Mouth / tongue ulcers
- Nosebleed
- Dry nose/ mouth/ throat
- Nasal congestion
- Loss of voice
- Thirst
- Excessive phlegm
- TMJ
- Facial pain
- Gum problems

**Skin & Hair**

- Hives / rashes
- Eczema/ psoriasis
- Night sweating
- Excess sweating
- Dry skin
- Skin texture changes
- Easy bruising
- Mole/ lump changes
- Itching
- Dry hair
- Hair loss
- Change in hair color
- Hair texture changes

**Respiratory**

- Shortness of breath
- Tight chest
- Asthma / wheezing
- Chronic cough
- Wet cough
- Dry cough
- Coughing up phlegm
- Coughing up blood
- Pneumonia

**Cardiovascular**

- High blood pressure
- Low blood pressure
- Chest pain / tightness
- Palpitations
- Rapid heart beat
- Irregular heart beat
- Poor circulation
- Swollen ankles
- Phlebitis
- Anemia

**Gastrointestinal**

- Nausea
- Indigestion
- Stomach pain
- Diarrhea
- Constipation
- Poor appetite
- Excessive hunger
- Vomiting
- Gas

- Hiccups
- Acid regurgitation
- Bloating
- Bad breath
- Bloody stool
- Mucus in stool
- Hemorrhoids
- Gall Bladder disorder

**Musculoskeletal**

- Joint pain/disorder
- Sore muscles
- Weak muscles
- Difficulty walking
- Neck/shoulder pain
- Upper back pain
- Lower back pain
- Rib pain
- Reduced range of motion

**Neurological**

- Seizures
- Tremors
- Numbness or tingling
- Pain
- Paralysis
- Poor coordination

**Urinary**

- Painful urination
- Frequent urination
- Urgent urination
- Incomplete urination
- Decreased urine flow
- Blood in urine
- Unable to hold urine
- Wake to urinate
- Kidney stones
- Lower abdominal pain

**Male Reproductive**

- Increased / decreased libido
- Impotence
- Premature ejaculation
- Nocturnal emission
- Pain of genitalia
- Genital itching
- Testicular pain / swelling
- Lumps in testicle(s)

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**OB/GYN History**

Date of last period: \_\_\_/\_\_\_/\_\_\_ Avg. duration of flow: \_\_\_\_\_ Avg. length of cycle: \_\_\_\_\_

Age at first menses: \_\_\_\_\_ Number of pregnancies: \_\_\_\_\_ Number of abortions: \_\_\_\_\_

Age at menopause: \_\_\_\_\_ Number of live births: \_\_\_\_\_ Number of miscarriages: \_\_\_\_\_

Do you use birth control? Y / N If yes, please describe: \_\_\_\_\_

Do you have any reason to suspect that you might be pregnant? Y / N

Are you currently trying to become pregnant? Y / N

**Have you ever had any of the following?**

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Abnormal pap smear | <input type="checkbox"/> Endometriosis    | <input type="checkbox"/> Hysterectomy    |
| <input type="checkbox"/> Abnormal mammogram | <input type="checkbox"/> Uterine fibroids | <input type="checkbox"/> Breast cancer   |
| <input type="checkbox"/> IUD or Hormone IUD | <input type="checkbox"/> Mastectomy       | <input type="checkbox"/> Cervical cancer |
| <input type="checkbox"/> Ectopic pregnancy  | <input type="checkbox"/> Lumpectomy       | <input type="checkbox"/> Uterine cancer  |

**Please write "C" next to symptoms you currently experience, and "P" next to symptoms you have experienced in the past year.**

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Decreased libido         | <input type="checkbox"/> Breast lumps             | <input type="checkbox"/> Bleeding between cycles  |
| <input type="checkbox"/> Increased libido         | <input type="checkbox"/> Breast tenderness        | <input type="checkbox"/> Blood clots              |
| <input type="checkbox"/> PMS                      | <input type="checkbox"/> Excess vaginal discharge | <input type="checkbox"/> Heavy bleeding (weeks)   |
| <input type="checkbox"/> Pain before menstruation | <input type="checkbox"/> Vaginal odor             | <input type="checkbox"/> Pain during intercourse  |
| <input type="checkbox"/> Pain during menstruation | <input type="checkbox"/> Vaginal sores            | <input type="checkbox"/> Bleeding after menopause |
| <input type="checkbox"/> Pain after menstruation  | <input type="checkbox"/> Vaginal dryness          | <input type="checkbox"/> Hot flashes              |
| <input type="checkbox"/> Bone density changes     | <input type="checkbox"/> Vaginal itching          |   |
| <input type="checkbox"/> Fibrocystic breasts      | <input type="checkbox"/> Vaginal pain             |   |

**Do you experience any of the following pre-menstrual symptoms?**

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Nausea        | <input type="checkbox"/> Breast swelling   | <input type="checkbox"/> Suicidal feelings        |
| <input type="checkbox"/> Vomiting      | <input type="checkbox"/> Breast tenderness | <input type="checkbox"/> Irritability             |
| <input type="checkbox"/> Headaches     | <input type="checkbox"/> Water retention   | <input type="checkbox"/> Other emotions? _____    |
| <input type="checkbox"/> Migraines     | <input type="checkbox"/> Anxiety           | <input type="checkbox"/> Dull pain, where? _____  |
| <input type="checkbox"/> Food cravings | <input type="checkbox"/> Depression        | <input type="checkbox"/> Sharp pain, where? _____ |

**Medical Screening:**

Most recent pap smear: \_\_\_/\_\_\_/\_\_\_ What was the result? Normal / Abnormal

Most recent mammogram: \_\_\_/\_\_\_/\_\_\_ What was the result? Normal / Abnormal

**Hormone Replacement Therapy**

Are you currently using Hormone Replacement Therapy? Y / N

Type/ Dose: \_\_\_\_\_ How long have you been on HRT? \_\_\_\_\_

Any side effects? \_\_\_\_\_