Date: _____Patient Name: _____

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 confidential. If you have questions, please ask. 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	Middle	Last name		
Street	City		State/Zip	
Home phone	Cell phone	Date of Birth	Sex	
	Work phone		Height	Weight
Email Address	Marital Status	Employment Status □ Full time □ Part time □ Student □ Retired □ Other		
Occupation / Title	Family Physician Name (PCP), Address and Telephone #:			
Would you like us to send a report to your PCP? □ Yes □ No				
Referred by:				
Emergency contact - Name (First & Last)	Emergency contact #	Relation to you		

Have you been treated by Acupuncturist or Chiropractor before? □Yes □No
Main problem(s) you would like us to help you with:
How long ago did this problem begin? Please be specific.
To what extent does this problem interfere with your daily activities, such as work, sleep, and sex.
Have you been given a diagnosis for this problem? If so, what?
What other kinds of treatment have you tried?

PAST MEDICAL HISTORY (please include date) Circle all that apply

Cancer Diabetes Hepatitis High Blood Pressure Heart Disease Rheumatic Fever

Thyroid Disease Seizures Venereal Disease Other

Surgeries
Significant trauma (auto accidents, falls, etc.)
Allergies (drugs, chemicals, foods)

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Family Medical History *Circle all that apply*

Diabetes Cancer High Blood Pressure Heart Disease Stroke Seizures

Asthma Allergies Other:

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

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

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

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

Please describe your average daily diet:

Morning:	Afternoon:	Evening:

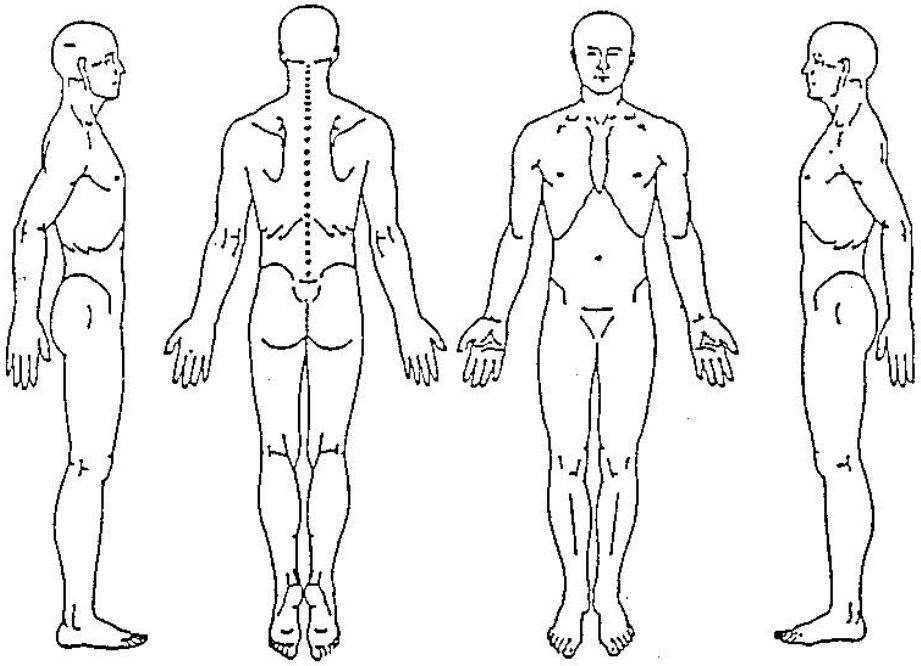
Do you smoke? If yes, how much?

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

How much water do you drink per day?	How much alcohol do you drink?

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

Please indicate any painful or distressed areas by circling the area.



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Please check if you have had (in the last three months):

General

- ☐ Fevers
- ☐ Sweat easily
- ☐ Bleed or bruise easily
- ☐ Peculiar tastes or smells
- ☐ Sudden energy drop (what time of day?)
- ☐ Poor sleeping
- ☐ Chills
- ☐ Weight loss
- ☐ Strong thirst (hot or cold drinks)
- ☐ Fatigue
- ☐ Night sweats
- ☐ Cravings
- ☐ Change in appetite
- ☐ Weight gain

Skin & Hair

- ☐ Rashes
- ☐ Itching
- ☐ Dandruff
- ☐ Change in hair or skin texture
- ☐ Any other hair or skin problems?
- ☐ Ulcerations
- ☐ Eczema
- ☐ Loss of hair
- ☐ Hives
- ☐ Pimples
- ☐ Recent moles

Head, eyes, ears, nose, and throat

- ☐ Dizziness
- ☐ Glasses
- ☐ Poor vision
- ☐ Cataracts
- ☐ Ringing in ears
- ☐ Sinus problems
- ☐ Grinding teeth
- ☐ Teeth problems
- ☐ Any other head or neck problems?
- ☐ Concussions
- ☐ Eye strain
- ☐ Night blindness
- ☐ Blurry vision
- ☐ Poor hearing
- ☐ Nose bleeds
- ☐ Facial pain
- ☐ Jaw clicks
- ☐ Migraines
- ☐ Eye pain
- ☐ Color blindness
- ☐ Earaches
- ☐ Spots in front of eyes
- ☐ Recurrent sore throats
- ☐ Sores on lips or tongue
- ☐ Headaches (where, when?)

Cardiovascular

- ☐ High blood pressure
- ☐ Irregular heartbeat
- ☐ Cold hands or feet
- ☐ Blood clots
- ☐ Any other heart or blood vessel problems?
- ☐ Low blood pressure
- ☐ Difficulty in breathing
- ☐ Swelling of hands
- ☐ Phlebitis
- ☐ Chest pain
- ☐ Fainting
- ☐ Swelling of feet

Respiratory

- ☐ Cough
- ☐ Bronchitis
- ☐ Difficulty in breathing when lying down
- ☐ Any other lung/breathing problems?
- ☐ Coughing blood
- ☐ Pneumonia
- ☐ Asthma
- ☐ Pain with a deep breath
- ☐ Production of phlegm
  What color?

Gastrointestinal

- ☐ Nausea
- ☐ Constipation
- ☐ Black stools
- ☐ Bad breath
- ☐ Bleeding gums
- ☐ Any other problems with your stomach or intestines?
- ☐ Vomiting
- ☐ Gas
- ☐ Blood in stools
- ☐ Rectal pain
- ☐ Abdominal pain or cramps
- ☐ Diarrhea
- ☐ Belching
- ☐ Indigestion
- ☐ Hemorrhoids
- ☐ Chronic laxative use

Genito-Urinary

- ☐ Pain upon urination
- ☐ Urgency to urinate
- ☐ Decrease in flow
- ☐ Do you wake up to urinate? How often?
- ☐ Frequent urination
- ☐ Unable to hold urine
- ☐ Impotency
- ☐ Any particular color to your urine:
- ☐ Blood in urine
- ☐ Kidney stones
- ☐ Sores on genitals

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☐ **Reproductive and gynecologic**

Are you pregnant? Yes No
Is it possible that you are pregnant? Yes No

☐ Pregnancies #:	☐ Live births #:	☐ Miscarriages #:
☐ Abortions #:	☐ Premature births #:	☐ Age of first menses
☐ Period between menses	☐ Duration of menses	☐ Unusual character (heavy, light)
☐ Irregular periods	☐ Painful periods	☐ Clots
☐ Last PAP	☐ Vaginal discharge	☐ Vaginal sores
☐ Breast lumps	☐ Menopause Age:	

Changes in body/psyche prior to menstruation

Do you practice birth control? What type and for how long?

Musculoskeletal

☐ Neck pain	☐ Muscle pain	☐ Knee pain
☐ Back pain	☐ Muscle weakness	☐ Foot/ankle pains
☐ Hand/wrist pains	☐ Shoulder pain	☐ Hip pain
☐ Any other joint or bone problems?		

Neuropsychological

☐ Seizures	☐ Dizziness	☐ Loss of Balance
☐ Areas of numbness	☐ Lack of coordination	☐ Poor memory
☐ Concussion	☐ Depression	☐ Anxiety
☐ Bad temper	☐ Easily susceptible to stress	

Have you ever been treated for emotional problems?
Have you ever considered or attempted suicide?
Any other neurological or psychological problems?

AUTHORIZATION

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

I authorize this office to release any information including the diagnosis and the records of any treatment or examination rendered to my child or me during the period of such medical care to third party payers and/or health practitioners.

I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or me or my dependants.

I authorize the Acupuncture Sanctuary to contact me with appointment reminders, information about treatment or other health related information.

NOTICE OF HIPPA PRIVACY PRACTICES

I have received or review the posted privacy practice notice for the Acupuncture Sanctuary, and understand the situations in which this practice may need to utilize or release my medical records.

I understand that this office will properly maintain my records, and will use all due means to protect my privacy as outlined in its privacy practice statement.

X_____

Signature of Patient (or parent if a minor) Date

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