New Patient Health History

PATIENT INFORMATION		Today's Date:
Patient's Name:	Gender:	Date of Birth:
Alias/Maiden Name:	Preferred name:	
Street Address:		
Home Phone:	Cell Phone: ( )	
Email Address:	May we send you emails about clinic events or newsletters? ☐ YES ☐ NO	
☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Domestic partnership ☐ Other _____		

EMERGENCY CONTACT	
Emergency Contact:	Relationship:
Emergency Contact Phone: ( )	Emergency Contact Office/Cell Phone: ( )

OTHER CARE PROVIDERS	
Provider's Name:	Provider Type:
Provider's Address:	Phone:
Provider's Name:	Provider Type:
Provider's Address:	Provider Type:

EMPLOYMENT	
I am currently: ☐ Full-Time ☐ Part-time ☐ Self-employed ☐ Student ☐ Unemployed ☐ Retired	
Job Title / Description:	Number of work/study hours per week:

GENERAL HEALTH

What is the primary concern associated with your visit today?

Onset: How long have you had this/these issues?

Does anything make the condition better? ☐ YES ☐ NO If yes, what?

Does anything make the condition worse? ☐YES ☐ NO If yes, what?

Have you been treated for this condition before? ☐ YES ☐ NO If yes, please describe.

Are you currently being treated for any other medical problems? ☐ YES ☐NO If yes, please describe.

Are there any other issues or health concerns you are hoping to work on?

Have you tried acupuncture before? ☐ YES ☐ NO If yes, please describe.

How did you hear about the clinic? ☐ Website ☐ Another Health Care Provider ☐ Advertisement

☐ Friend_____ ☐ Other _____

MEDICATIONS

Do you have allergies to medications? ☐YES ☐NO If yes, please describe.

List any pharmaceuticals, both prescription and over the counter, that you are currently taking:

List all herbal prescriptions and supplements you are taking:

DIET AND NUTRITION- Please describe your typical diet.
Breakfast:
Lunch
Dinner
Snacks

Risk Factors

Are you currently using any of the following substances regularly, or have you used them in the past?

Substance	Current Usage	Used in the past	Amount per day/week	Comments
Caffeine	☐	☐		
Tobacco	☐	☐		
Alcohol	☐	☐		
Other	☐	☐		

Health History

	Self	Mother	Father	Sibling	Comments
Allergies (environmental)	☐	☐	☐	☐	
Anemia	☐	☐	☐	☐	
Anxiety / Panic Attacks	☐	☐	☐	☐	
Asthma	☐	☐	☐	☐	
Autoimmune Disease	☐	☐	☐	☐	
Bladder Disorder	☐	☐	☐	☐	
Blood Disorder	☐	☐	☐	☐	
Cancer	☐	☐	☐	☐	
Constipation/Diarrhea	☐	☐	☐	☐	
COPD/Emphysema	☐	☐	☐	☐	
Depression	☐	☐	☐	☐	
Diabetes (type I or type II)	☐	☐	☐	☐	
Drug/ Alcohol Abuse	☐	☐	☐	☐	
Headaches	☐	☐	☐	☐	
Heart Attack	☐	☐	☐	☐	
Heart Disease	☐	☐	☐	☐	
Hepatitis	☐	☐	☐	☐	
High Blood Pressure	☐	☐	☐	☐	
High Cholesterol	☐	☐	☐	☐	
Kidney Disorder	☐	☐	☐	☐	
Migraines	☐	☐	☐	☐	
Seizures	☐	☐	☐	☐	
Sexually Transmitted Infection	☐	☐	☐	☐	
Stomach/Intestinal Disorder	☐	☐	☐	☐	
Stroke	☐	☐	☐	☐	
Thyroid Disorder	☐	☐	☐	☐	

Signs and Symptoms (check if currently experiencing the issue or have experienced it in the past)

General Symptoms	Current	Past
Anxiety/Mood swings	☐	☐
Chills	☐	☐
Cold hands/feet	☐	☐
Crave bitter foods	☐	☐
Crave salty foods	☐	☐
Crave sour foods	☐	☐
Crave spicy foods	☐	☐
Crave sweets	☐	☐
Decreased smell	☐	☐
Decreased taste	☐	☐
Depression	☐	☐
Dreams/nightmares	☐	☐
Fatigue	☐	☐
Fever	☐	☐
Insomnia	☐	☐
Irritability	☐	☐
Night sweats	☐	☐
Often feel afraid	☐	☐
Often feel angry	☐	☐
Often feel sad	☐	☐
Often indecisive	☐	☐
Often worried	☐	☐
Poor memory	☐	☐

Neurological Symptoms	Current	Past
Seizures	☐	☐
Tremors	☐	☐
Numbness/Tingling	☐	☐
Paralysis	☐	☐

Eye Symptoms	Current	Past
Corrective lenses	☐	☐
Blurred vision	☐	☐
Poor night vision	☐	☐
Spots or floaters	☐	☐
Eye inflammation	☐	☐
Dryness	☐	☐
Tearing	☐	☐
Glaucoma	☐	☐
Cataracts	☐	☐

Head and Neck Symptoms	Current	Past
Headaches	☐	☐
Migraines	☐	☐
Stiff neck	☐	☐
Dizziness	☐	☐
Fainting	☐	☐
Swollen glands	☐	☐

Ear Symptoms	Current	Past
Ear ringing	☐	☐
Hearing loss	☐	☐
Infections	☐	☐
Earache	☐	☐
Vertigo	☐	☐

Nose/Throat Symptoms	Current	Past
Sinus infections	☐	☐
Allergies	☐	☐
Dry throat	☐	☐
Sore throat	☐	☐
Difficulty swallowing	☐	☐
Bad breath	☐	☐
Bleeding gums	☐	☐
Grinding teeth	☐	☐
Nasal congestion	☐	☐
Nosebleeds	☐	☐
Loss of voice	☐	☐

Skin Symptoms	Current	Past
Hives	☐	☐
Rashes	☐	☐
Eczema/Psoriasis	☐	☐
Dry skin	☐	☐
Easy bruising	☐	☐
Changes in moles	☐	☐
Itching	☐	☐
Measles	☐	☐
Chickenpox	☐	☐
Shingles	☐	☐
Acne	☐	☐

Signs and Symptoms Continued

Respiratory Symptoms	Current	Past
Difficulty breathing	☐	☐
Wheezing	☐	☐
Asthma	☐	☐
Chronic cough	☐	☐
Wet cough	☐	☐
Cough with phlegm	☐	☐
Cough with blood	☐	☐

Cardiovascular Symptoms	Current	Past
High blood pressure	☐	☐
Low blood pressure	☐	☐
Chest pain or tightness	☐	☐
Palpitations	☐	☐
Rapid heartbeat	☐	☐
Poor circulation	☐	☐
Swollen ankles	☐	☐
Anemia	☐	☐

Gastrointestinal Symptoms	Current	Past
Nausea	☐	☐
Vomiting	☐	☐
Acid reflux/GERD	☐	☐
Stomach pain	☐	☐
Abdominal bloating	☐	☐
Indigestion	☐	☐
Poor appetite	☐	☐
Change in appetite	☐	☐
Gas: Belching	☐	☐
Gas: Flatulence	☐	☐
Diarrhea	☐	☐
Constipation	☐	☐
Dry/hard stool	☐	☐
Blood in stool	☐	☐
Hemorrhoids	☐	☐
Jaundice	☐	☐
Liver disorder	☐	☐
Gall bladder disorder	☐	☐

Musculoskeletal Symptoms	Current	Past
Joint pain	☐	☐
Weak muscles	☐	☐
Sore/weak knees	☐	☐
Sore/weak ankles	☐	☐
Difficulty walking	☐	☐
Neck/shoulder pain	☐	☐
Upper/mid back pain	☐	☐
Lower back pain	☐	☐
Rib pain	☐	☐
Limited motion	☐	☐
Muscle spasms	☐	☐

Genito-Urinary Symptoms	Current	Past
Frequent urination	☐	☐
Painful urination	☐	☐
Urgent urination	☐	☐
Blood in urine	☐	☐
Incomplete urination	☐	☐
Bedwetting	☐	☐
Wake to urinate	☐	☐
Kidney stone	☐	☐
Increased sex drive	☐	☐
Decreased sex drive	☐	☐
Genital pain/itching	☐	☐
Genital lesions	☐	☐
Genital discharge	☐	☐
Infertility	☐	☐

Female Specific Symptoms	Current	Past
Frequent urinary tract infections	☐	☐
Frequent vaginal infections	☐	☐
Pelvic inflammatory disease	☐	☐
Abnormal PAP smear	☐	☐
Irregular periods	☐	☐
Premenstrual syndrome	☐	☐
Painful menstrual bleeding	☐	☐
Abnormal bleeding	☐	☐
Menopause symptoms	☐	☐
Breast lumps	☐	☐

Male Specific Symptoms	Current	Past
Premature ejaculation	☐	☐
Testicular lumps	☐	☐
Prostatitis	☐	☐
Impotence	☐	☐

FEMALE REPRODUCTIVE HEALTH						
Age of first menstruation			First day of last menses:		Duration of flow (# of days):	Clots: (yes, no)
Color of Blood:			Number of days in cycle (21, 28, 33, etc.):		Consistency (thin, thick):	
PMS:	Cramps	Pain	Breast Tenderness	Other		
	☐	☐	☐	☐		
Current method of contraception:			Contraception History:			
Have you ever been pregnant? Yes/No			Are you currently pregnant? yes no			Due Date:
Date of menopause:			Hormone Replacement Therapy? Yes/No		**I understand that I must notify my practitioner if I become pregnant**	

PRIOR HOSPITALIZATIONS OR SURGERIES		
Year:	Operation/Condition:	
Year:	Operation/Condition:	
Year:	Operation/Condition:	

Please provide any additional information you feel would be helpful