Confidential Health History

Name: ____ Date: ______________

Address: ____

City: ____________________________ State: _________ Zip: ______________

Daytime Phone: _______________ Evening Phone: ____________ Cell: ____________

E-mail: ____

Date of Birth: ___________ Age: _____ Marital Status: _________________________

Employer: _____________________________________ Hrs/Wk: ____________

Type of work: ______________________________ Repetitive actions: ____________

Emergency Contact: ____

Relationship: _________________________ Phone: _________________________

Primary Physician: ___________________________ Phone: _____________________

Other Healthcare Provider(s): _____________________ Phone: ____________________

How did you hear about *FSPA Community Acupuncture*? ______________________________

Have you ever tried: Acupuncture?_____ Chinese Herbs? _____ Other Herbs? ____ Massage? _____

Spiritual Direction? ______ Healing Touch/Reiki?________ Homeopathy? _______ Chiropractic? _____

Other holistic healing modalities? ____

May we send postcards or promotional materials to the address listed above? Yes _____ No _____

Reason for today's visit: ____

____

How long have you had this condition? ____________________ Is it getting worse? _________

What do you feel is the cause of this condition? _______________________________

Does it interfere with: Work ______ Sleep ______ Eating _______ Activity _______ Relating _______

What makes it feel better? _________________________ Worse? __________________

Have you seen a physician about this? ___________ When? _________________________

Diagnosis, if any: ____

What tests were performed and what were the results? (include x-rays, scans, blood work, etc.) __________

____

Who else did you see anyone else about this condition? ____________________________

What did s/he recommend? ____

What is the severity of your health concern TODAY? (Circle only one number)

0	1	2	3	4	5	6	7	8	9	10

No problem at all — As bad as it can be

On average, what was the typical severity of your health concern in the LAST WEEK?

0	1	2	3	4	5	6	7	8	9	10

No problem at all — As bad as it can be

For what else do you regularly see a doctor? (Include all diagnoses and date of onset) ____________________

____

	Describe (include dates)
Past Traumas	
Accidents	
Surgeries	
Allergies (food, medicine, etc.)	
Parents' Health	
Siblings' Health	
Children's Health	

For the following, please **circle all that apply to you.**

Body Temperature and Perspiration

Generally feel warm	Generally feel cool	Don't notice my body temperature
Feel chills	Feel feverish	Hot flashes Sweat at night
Sweat at rest/easily	Prefer hot drinks	Prefer cold drinks

Other:____

Head, Ears, Eyes, Nose, and Throat

Headaches	Gum Problems	Glasses	Poor Night Vision	Excess Sputum
Migraines	Mouth Sores	Eye Strain	Cataracts	Swollen Glands
Concussion	Dry Mouth	Eye Pain	Floaters	Enlarged Thyroid
TMJ	Poor Hearing	Dry Eyes	See Halos	Facial Pain
Teeth Grinding	Ear Aches	Red Eyes	Glaucoma	Frequent Nose Bleeds
Teeth Problems	Ringing in Ears			Sinus Problems

Other: ____

Respiratory and Cardiovascular

Short of Breath	Chest Pain/Tightness	Heart Murmur	Implantable Defibrillator
Can't lie flat	Palpitations	Pacemaker	Blood Clots
Wheezing	Irregular Heartbeat	Stent	Varicose Veins/Phlebitis

Cough: Dry / hacking / tickly / recurring / productive / other: ______________________________________

Sputum color: clear / white / yellow / green / brown / red / thick / thin / other: _________________________

Other :____

Diet and Thirst

After eating, feel: tired / bloated / energized / pain / gas / other: ____________________________________

What do you eat: ____

What do you NOT eat: ____

Appetite: good / fair / poor Cravings: sweet / salty / meat / other ________________________________

Eat 3 meals a day Skip meals Taste in mouth: bitter / sweet / metallic / other __________________

Feel thirsty How much do you drink in 24 hours? ____

Other: ____

Gastrointestinal

Acid reflux	Trouble Swallowing	Laxative Use	Bloody Stools
Bad Breath	Heartburn	Diarrhea	Gallstones
Bloating	Nausea	Constipation	Hemorrhoids
Gas	Vomiting	Black Tarry Stools	Rectal Pain
Hiccup	Intestinal Cramps	Mucus in Stools	Itchy/Burning Anus

Bowel movements per day ____ (or week ____) Texture: dry / hard / soft / unformed / watery

Other: ____

Genitourinary

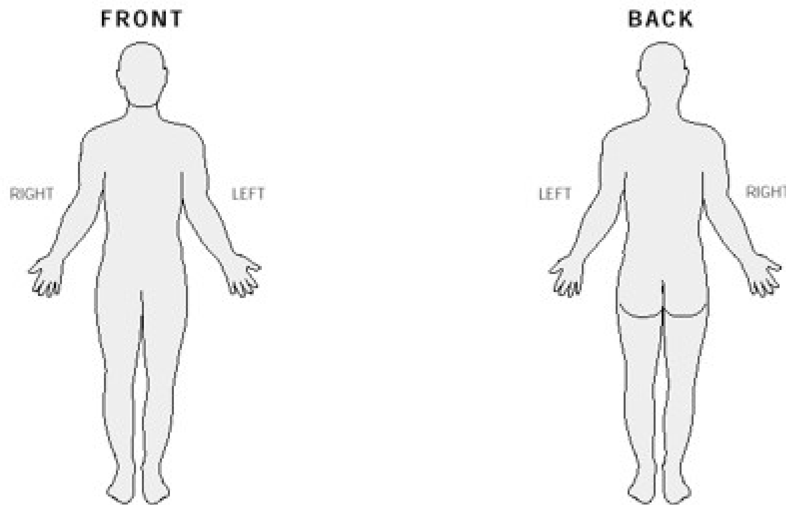
Burning Urination	Bloody Urination	Hernia	Premature Ejaculation
Painful Urination	Incomplete Urination	Impotence	Prostate Problems
Frequent Urination	Incontinence	Kidney Stones	Abnormal Penile Discharge
Urgent Urination	Clear/Bright/Dark Urine	Urinary Stones	Change in Libido / Sex Drive

Other: ____

Musculoskeletal Pain

Mark the area with the symbol that best describes your pain:

Aching Pain ******** Pins and needles oooooooo Burning xxxxxxxx
Stabbing //////// Numbness = = = = = = = =



Other: ____________________

Skin and Hair

Acne	Hives	Infections: ____________
Dandruff	Itching	Rashes: ____________
Eczema	Psoriasis	Ulcerations/Non-healing sores: ____________

Other: ____________________

Neuropsychological

ADD/ADHD	Easily Stressed	Panic Disorder	Suicidal Thoughts
Anxiety	Irritable	Post-Traumatic Stress	Attempted Suicide
Bipolar	Moody	Schizophrenia	Abuse Survivor
Depression	Numbness	Seizures	Currently in Therapy

Other: ____________________

Sleep

Wake up rested	Hard to fall asleep	Wake up easily	Disturbed sleep
Nightmares	Frequent dreaming	Up at night to urinate	Hard to get back to sleep
Nap in the day	"Morning" person	"Night owl"	Wet bed

Hours of sleep per night: __________ Quality of sleep: Excellent / good / fair / poor
Other: ____________________

Lifestyle

Active	Sedentary	Regular exercise
Good social network	Feel part of a community	Someone special in my life
Healthy relationships	Prayer	Meditation
Hazardous job	Stressful job	Stressful home life
Stressful relationship	Drink alcohol	Smoke cigarettes / cigars / pipe / chew
Marijuana	Other recreational drugs	Financial concerns

Other: ____

Females Only

Age periods began: _______ Date of last period: _______________ Days in cycle: ____________
Past pregnancies: ______ Live births: ______ Miscarriages: _____ Abortions: _____
Pregnant now Trying to conceive Birth control (Type:_____________________)
Menopausal Hysterectomy Hormone replacement PMS
Irritable before period Bloated before period Tender / swollen breasts before period

If still menstruating, periods are: regular / irregular / painful If painful: before / during / after period?
Color of menstrual blood: pale red / bright red / dark red / purple Volume: Heavy / Light
Clots: small / large Regularly examine breasts Regular mammograms
Vaginal discharge: none / white / yellow / foul-smelling / brown / bloody Vaginal sores / lesions
Date of last PAP smear: __________ Normal / Abnormal
Other: ____

Is there anything else you would like to share?

Everything I have written is true; I will update this office when there are significant changes.

____ Date: _______________________
Signature