



SANTA ROSA
COMMUNITY
ACUPUNCTURE

healthy body • healthy mind • healthy budget

HEALTH HISTORY FORM

NAME _____ DATE _____

ADDRESS _____

HOME PHONE _____ ALTERNATE PHONE _____

EMAIL _____

DATE OF BIRTH _____ M ____ F ____ MARITAL STATUS _____ NO. OF CHILDREN _____

OCCUPATION _____ HEIGHT _____ WEIGHT _____

EMPLOYER _____

REFERRED BY _____

EMERGENCY CONTACT _____ PHONE _____

NAME AND ADDRESS OF PRIMARY CARE PRACTITIONER _____

WHAT CONDITIONS ARE YOUR PRIMARY CONCERNS?

1 _____

2 _____

3 _____

FAMILY HISTORY (CHECK ANY DISORDERS YOU OR YOUR FAMILY HAVE EXPERIENCED)

	You	FATHER	MOTHER	SIBLING	CHILDREN
ALLERGIES	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
BLOOD DISORDER/ANEMIA	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
CANCER/TUMORS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
DIABETES	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
HEART DISORDER	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
HIGH BLOOD PRESSURE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
SEIZURES	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
STROKE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
OTHER	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

PLEASE LIST ANY MEDICATIONS OR SUPPLEMENTS THAT YOU ARE CURRENTLY TAKING

FOR WHAT CONDITIONS?

DATE OF LAST PHYSICAL EXAMINATION _____

► **Diet**

CRAVINGS (SWEET, SALTY, BITTER, GREASY, SPICY) _____

LIST ANY KNOWN FOOD ALLERGIES _____

HOW MANY CUPS A DAY DO YOU DRINK OF THE FOLLOWING? WATER _____ SODA _____ COFFE _____ TEA _____ ALCOHOL _____

ARE YOU ALWAYS THIRSTY? _____ NEVER THIRSTY? _____

DO YOU PREFER HOT, ICED, OR ROOM TEMPERATURE DRINKS? (CIRCLE ONE)

DO YOU PERSPIRE DURING THE DAY? _____ DO YOU PERSPIRE AT NIGHT? _____

► **Gastrointestinal**

DO YOU HAVE OR HAVE YOU HAD? (CHECK ALL THAT APPLY)

- | | | |
|---|---------------------------------------|--------------------------------------|
| <input type="checkbox"/> ABDOMINAL PAIN | <input type="checkbox"/> BLOATING | <input type="checkbox"/> INDIGESTION |
| <input type="checkbox"/> ACID REFLUX | <input type="checkbox"/> HEMORRHOIDS | <input type="checkbox"/> NAUSEA |
| <input type="checkbox"/> BELCHING | <input type="checkbox"/> HERNIA | <input type="checkbox"/> ULCERS |
| BOWEL MOVEMENTS: HOW OFTEN? _____ | <input type="checkbox"/> CONSTIPATION | <input type="checkbox"/> DIARRHEA |

► **Sleep and energy**

HOW IS YOUR ENERGY LEVEL? (100% IS BEST. WHAT IS YOUR PERCENTAGE?) _____

DO YOU HAVE OR HAVE YOU HAD? (CHECK ALL THAT APPLY)

- | | | |
|--|--|---|
| <input type="checkbox"/> ANXIETY/NERVES | <input type="checkbox"/> DISTURBED SLEEP | <input type="checkbox"/> RECENT DIVORCE OR MAJOR STRESS |
| <input type="checkbox"/> DEPRESSION | <input type="checkbox"/> FEAR | <input type="checkbox"/> RESTLESSNESS |
| <input type="checkbox"/> DIFFICULTY CONCENTRATING | <input type="checkbox"/> PANIC ATTACKS | <input type="checkbox"/> WAKING UP AT _____ AM/PM |
| <input type="checkbox"/> DIFFICULTY FALLING ASLEEP | <input type="checkbox"/> POOR MEMORY | |

HAVE YOU EVER TAKEN ANTIDEPRESSANTS OR SLEEPING PILLS? _____ WHAT KIND? _____

► **Muscular-skeletal**

DO YOU HAVE OR HAVE YOU HAD? (CHECK ALL THAT APPLY)

- | | | |
|--------------------------------------|--|------------------------------------|
| <input type="checkbox"/> ARTHRITIS | <input type="checkbox"/> JOINT PAIN | <input type="checkbox"/> BACK PAIN |
| <input type="checkbox"/> MUSCLE PAIN | <input type="checkbox"/> PAIN ELSEWHERE IN THE BODY, & IF SO, WHERE? _____ | |

► **Respiratory, ENT & Head**

DO YOU SMOKE? _____ HOW MANY TIMES A DAY? _____ FOR HOW MANY YEARS? _____

DO YOU HAVE OR HAVE YOU HAD? (CHECK ALL THAT APPLY)

- | | | |
|---|---|---|
| <input type="checkbox"/> ASTHMA | <input type="checkbox"/> DIZZINESS | <input type="checkbox"/> FREQUENT HEADACHES |
| <input type="checkbox"/> BLEEDING GUMS | <input type="checkbox"/> DRY MOUTH | <input type="checkbox"/> MIGRAINES |
| <input type="checkbox"/> CLOGGED/POPPING EARS | <input type="checkbox"/> FREQUENT COLDS | <input type="checkbox"/> RINGING IN EARS |

► **Cardiovascular**

DO YOU HAVE OR HAVE YOU HAD? (CHECK ALL THAT APPLY)

- | | | |
|---|---|---|
| <input type="checkbox"/> COLD HANDS/FEET | <input type="checkbox"/> LOW BLOOD PRESSURE | <input type="checkbox"/> SWOLLEN HANDS/FEET |
| <input type="checkbox"/> HEART MURMUR | <input type="checkbox"/> PALPITATIONS | <input type="checkbox"/> VARICOSE VEINS |
| <input type="checkbox"/> HIGH BLOOD PRESSURE | <input type="checkbox"/> POOR CIRCULATION | |
| <input type="checkbox"/> IRREGULAR HEART BEAT | <input type="checkbox"/> SPIDER VEINS | |

► **Urinary** (CHECK ALL THAT APPLY)

- | | |
|---|---|
| <input type="checkbox"/> FREQUENT URINATION, HOW OFTEN? _____ | <input type="checkbox"/> INCONTINENCE/LEAKING |
| <input type="checkbox"/> BURNING SENSATION | <input type="checkbox"/> BLADDER INFECTION |

► **Gynecological**

ARE YOU STILL MENSTRUATING? HOW OFTEN ARE YOUR CYCLES? _____

DO YOU HAVE OR HAVE YOU HAD? (CHECK ALL THAT APPLY)

- | | | |
|--|---|---|
| <input type="checkbox"/> IRREGULAR MENSES | <input type="checkbox"/> HEAVY FLOW, WHAT DAY/S OF CYCLE? _____ | |
| <input type="checkbox"/> PAINFUL PERIODS, WHAT DAY/S OF CYCLE? _____ | DATE OF LAST MENSTRUAL PERIOD _____ | |
| <input type="checkbox"/> PMS, WHAT SYMPTOMS? _____ | | |
| <input type="checkbox"/> BLOOD CLOTS | | |
| <input type="checkbox"/> UTERINE FIBROIDS OR CYSTS | <input type="checkbox"/> ENDOMETRIOSIS | <input type="checkbox"/> CYSTIC BREASTS |
| <input type="checkbox"/> PERIMENOPAUSAL, WHAT SYMPTOMS? _____ | | |
| <input type="checkbox"/> MENOPAUSAL | WHAT WAS THE DATE OF LAST PERIOD? _____ | |

ARE THERE ANY OTHER HEALTH CONDITIONS WE SHOULD BE INFORMED OF?

Thank you!

FOR ACUPUNCTURIST USE

Dx:

PTS:

Rx:

T:

NOTES:

P: