Atlantic Sky Acupuncture Health History Questionnaire

Name: _____ Date of birth: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: (day) _____ (evening): _____ (cell): _____

Email address: _____

Occupation: _____

Who referred you/How did you hear about us? _____

Your primary health care provider: _____ Phone: _____

Emergency contact: _____ Phone: _____

What is your reason(s) for seeking acupuncture?

Symptom #1	Symptom #2	Symptom #3
How long have you had this issue/condition/pain?	How long have you had this issue/condition/pain?	How long have you had this issue/condition/pain?
What makes it better/worse?	What makes it better/worse?	What makes it better/worse?

Have you been given a diagnosis for this issue(s)? _____

Have you tried other treatments to address this issue(s)? _____

Medical History. Please list the following information:

Illnesses		
Surgeries		
Significant trauma (motor vehicle accidents, fractured bones, etc.)		
Medications/Supplements (please list all meds, herbs, vitamins and OTC drugs)		
Allergies/Sensitivities (please list any foods, drugs, medications, environmental factors, chemicals or materials you are allergic to)		

Do you have, or have you ever had the following conditions? Please circle all that apply:

• alcoholism • allergies • arthritis • asthma • anxiety • chronic fatigue • diabetes

• fibromyalgia • heart disease • high blood pressure • hypo/hyperglycemia • HIV

• impotence • infertility • IBS • kidney disease • Lyme disease

• osteoporosis • Raynaud's • seizures/epilepsy • stroke • thyroid disease

• hepatitis (type:_____) • cancer (type: _____) • mental illness (type: _____)

Do you have any medical devices in your body (pace-maker, knee replacement, etc.)?

_____

Lifestyle. Please provide the following information:

Do you exercise? Type/frequency/duration?_____

Do you smoke? _____ How often?_____

Do you drink caffeine? _____ How often? _____

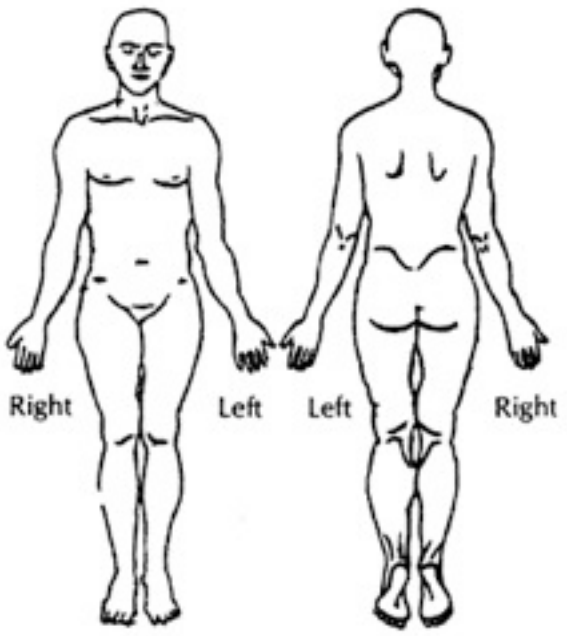
Do you drink alcohol? _____ How often? _____

Do you observe any dietary restrictions? _____

What foods do you crave? Or avoid? _____

How many hours a night do you sleep? _____ Do you wake up rested? _____

Musculoskeletal pain. Please mark any painful or distressed area(s) on the diagram below.



On a pain scale of 1 (no pain) to 10 (maximum pain), what is your pain level today? _____

Recent Condition or Symptoms. Please check the boxes for any of these items that you may have experienced in the last three (3) months. If the issue is of a chronic or persistent nature, please circle the item as well.

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General

__ bleed/bruise easily
__ cravings
__ localized weakness
__ poor appetite
__ weight gain
__ change in appetite
__ fatigue
__ night sweats
__ poor sleeping
__ weight loss
__ chills
__ fevers
__ sweat easily
__ strong thirst
__ tremors

Skin/Hair

__ eczema
__ loss of hair
__ itching
__ dandruff
__ hives
__ rashes
__ dryness
__ pimples
__ recent moles

Head/Nose/Throat

__ headaches
__ dizziness
__ swollen glands
__ strep throat
__ blurred vision
__ eye inflammation
__ poor night vision
__ spots/floaters
__ ear infections
__ hearing loss
__ ringing in ears
__ itchy ears

Cardiovascular

__ chest pain/tightness
__ poor circulation
__ swollen ankles
__ palpitations
__ shortness of breath
__ cold hands/feet
__ rapid heart beat
__ low blood pressure

Gastrointestinal

__ nausea
__ constipation
__ blood in stool
__ heartburn
__ diarrhea
__ stomach pain
__ hemorrhoids
__ gas
__ indigestion
__ excessive hunger
__ gallbladder disorder
__ ulcer

Respiratory

__ chronic cough
__ wheezing/asthma
__ pneumonia
__ coughing up phlegm
__ frequent colds
__ sinus infections
__ difficulty breathing
__ bronchitis

Neurological

__ seizures
__ poor memory
__ numbness/tingling limbs
__ hard to focus/concentrate
__ loss of balance

Urogenital

__ painful urination
__ weak urinary stream
__ urinary urgency
__ kidney stones
__ incontinence
__ wake at night to urinate

Men's Health

__ enlarged prostate
__ erectile dysfunction
__ impotence
__ low libido
__ fertility issues

Women's Health

__ painful periods
__ endometriosis
__ fertility issues
__ menopause issues
__ PCOS
__ history of miscarriage
__ fibroids/ovarian cysts
__ frequent yeast infections
__ PMS

Emotional

__ depression
__ panic attacks
__ irritable/angers easily
__ anxiety/worry
__ mood swings
__ insomnia
__ easily stressed out
__ grief/sadness