Health History

Date: ____ / ____ / _____

Name:	Gender:	Pronoun:	Age:

Address:	City:	State:	Zip Code:

Home Phone #:	Other Phone #: Work Cell Other	Email:

Date of Birth:	City of Birth:	State of Birth:

Height:	Weight:	Relationship Status: ❒ Single ❒ Married ❒ Separated ❒ Divorced ❒ Widowed ❒ Living w/partner ❒ Other: _____

Employer:	Occupation:

Physician:	Physician's Phone #:

How did you hear of our clinic?	Have you been treated by Acupuncture or Oriental Medicine Before? ❍ No ❍ Yes: when ____/____/____

MAIN COMPLAINTS

Please write in your top 3 health complaints / concerns in order of importance to you. Circle the items that make it better or worse and mark on the scale from 1-10 the severity of the condition (1=no symptoms, 10=worst ever)

1 _____

When did this start? _____ago
Heat makes it: better no change worse
Cold makes it: better no change worse
Damp weather: better no change worse
Exercise / Activity: better no change worse

1 ——— 10

2 _____

When did this start? _____ago
Heat makes it: better no change worse
Cold makes it: better no change worse
Damp weather: better no change worse
Exercise / Activity: better no change worse

1 ——— 10

3 _____

When did this start? _____ago
Heat makes it: better no change worse
Cold makes it: better no change worse
Damp weather: better no change worse
Exercise / Activity: better no change worse

1 ——— 10

_____

Check the ❒ if you have / had the condition and note the year it started.
Check the ❍ if there is a family history of the condition.

	YOU	Year	FAMILY
Cancer type(s)? _____	❒	_____	❍
Diabetes	❒	_____	❍
Hepatitis	❒	_____	❍
High Blood Pressure	❒	_____	❍
Heart Disease	❒	_____	❍
Stroke	❒	_____	❍
Seizure Disorder	❒	_____	❍
Thyroid Disease	❒	_____	❍
Asthma	❒	_____	❍
Pacemaker	❒	_____	❍
Osteoporosis	❒	_____	❍
Herpes	❒	_____	❍
AIDS / HIV	❒	_____	❍
Other STD	❒	_____	❍
Rheumatic Fever	❒	_____	❍
Alcoholism	❒	_____	❍
Allergies type(s)? _____	❒	_____	❍
Mental Illness	❒	_____	❍
Kidney Disease	❒	_____	❍
Anemia	❒	_____	❍

HABITS

	Amount / Week	If Quit, Year?
Coffee / Tea	_____	_____
Soda	_____	_____
Tobacco	_____	_____
Alcohol	_____	_____
Drugs	_____	_____

EXERCISE

Do you exercise regularly? ⑤ Yes ⑤ No
If so, what and how often:

_____
_____
_____

DIET

Do you have a special diet now or in the past? (vegetarian, vegan, raw, Atkins, etc.)
Describe w/ dates:

MEDICATONS

Please note what medications, herbs or supplements that you take regularly

_____
_____
_____

INJURIES & SURGURIES

Please note what happened to what body area and when it occurred (incl. dental)

_____
_____
_____

Please mark an X on the scales and check any boxes of symptoms you have had in the past month

TEMPERATURE

How warm / cold you feel (not in degrees); relative to other people do you wear more or less layers, etc.

COLD ——— HOT

- ❒ Cold hands or feet
- ❒ Chills
- ❒ Cold "in the bones"
- ❒ Areas of numbness

Thirst for cold / hot drinks

- ❒ Thirst, no desire to drink
- ❒ Absence of thirst
- ❒ Excessive thirst

- ❒ Night sweats
- ❒ Unusual sweats
  W hen_____ am / pm
  W here on body _____

- ❒ Hot hands, feet, chest
- ❒ Hot flashes
- ❒ Hot in afternoon
- ❒ Hot at night

MOISTURE

Your overall body moisture (hair, skin, mouth, bowels, etc.)

DRY ——— OILY

- ❒ Dry skin
- ❒ Dry hair
- ❒ Dry eyes
- ❒ Dry brittle nails

- ❒ Dry mouth
- ❒ Dry lips
- ❒ Dry throat
- ❒ Dry nose / Nosebleeds

Where on your body?

- ❒ Edema / Swelling _____
- ❒ Rashes _____
- ❒ Itching _____
- ❒ Dandruff

- ❒ Oily skin
- ❒ Oily hair
- ❒ Pimples
- ❒ Weight gain / loss

DIGESTION

DIARRHEA ——— CONSTIPATION

BM: How often? _____x / every _____days
Stools keep shape? ❒ Y ❒ N

- ❒ Alternating diarrhea & constipation (IBS)
- ❒ Indigestion

- ❒ Gas
- ❒ Bloating
- ❒ Belching
- ❒ Poor appetite

- ❒ Nausea / Vomiting
- ❒ Bad breath
- ❒ Heartburn
- ❒ Excessive hunger

- ❒ Dry Stools
- ❒ Difficult to pass
- ❒ Tired after BM
- ❒ Foul smelling stools

ENERGY

LOW ——— HIGH

- ❒ Sudden energy drop
  Time of day: _____ am / pm
- ❒ Energy drop after eating
- ❒ Fatigue

- ❒ Dependence on caffeine / stimulants
- ❒ Wired / ungrounded feeling
- ❒ Body / Limbs feel heavy
- ❒ Body / Limbs feel weak

- ❒ Shortness of breath
- ❒ Heart Palpitations
- ❒ Blood pressure High / Low
- ❒ Bleed / Bruise easy

- ❒ Hard to concentrate
- ❒ Poor memory
- ❒ Dizziness / lightheaded
- ❒ Headaches _____x / week

SLEEP

Hours per night _____

- ❒ Difficulty falling asleep
- ❒ Wake ___x/ night @_____am / pm
- ❒ Wake to urinate How oft en? _____
- ❒ Disturbing dreams
- ❒ Restless sleep
- ❒ Not rested upon waking

EMOTIONS

What emotion(s) dominate your experience?

- ❒ Anger
- ❒ Irritability
- ❒ Anxiety
- ❒ Worry
- ❒ Obsessive thinking
- ❒ Sadness

- ❒ Grief
- ❒ Depression
- ❒ Joy
- ❒ Fear
- ❒ Timid / shy
- ❒ Indecision

EYES, EARS NOSE THROAT

- ❒ Poor vision
- ❒ Night blindness
- ❒ Red eyes
- ❒ Itchy eyes
- ❒ Spots in front of eyes
- ❒ Sinus congestion
- ❒ Phlegm (color _____)

- ❒ Poor hearing
- ❒ Ringing in ears
- ❒ Excess earwax
- ❒ Sore throat
- ❒ Dental problems
- ❒ Mouth sores
- ❒ Cough

URINARY

Fluid in = fluid out? ❒ Y ❒ N

- ❒ Decrease in flow
- ❒ Dribbling
- ❒ Difficulty starting / stopping
- ❒ Incontinence
- ❒ Kidney stones

- ❒ Urgency to urinate
- ❒ Frequent urination
- ❒ Pain on urination
- ❒ Burning sensation
- ❒ Cloudy urine
- ❒ Blood in urine

REPRODUCTIVE

Are you sexually active? ❒ Y ❒ N

- ❒ Change of sexual drive: ↑ ↓
- ❒ Erectile dysfunction
- ❒ Premature ejaculation
- ❒ Sores on genitals
- ❒ Discharge

- ❒ Prostate disease
- ❒ Genital Pain
- ❒ Jock Itch
- ❒ Vasectomy
- ❒ Hernia
- ❒ Hemorrhoids

MENSES

Age at first menses: _____
Length of full cycle: _____ days
Length of menses: ____ days
Last menses start date: ____ / ____
# of pregnancies: ____
# of births: _____ premature _____
# of abortions / miscarriages: _____

- ❒ Heavy periods
- ❒ Light periods
- ❒ Painful periods
- ❒ Irregular periods
- ❒ Changes in body/ psyche prior to menstruation (PMS)

- ❒ Cramps
- ❒ Before bleeding
- ❒ First day
- ❒ During period
- ❒ Clots
- ❒ Breast tenderness

- ❒ Mood changes
- ❒ Fatigue w/ menses
- ❒ Digestive changes w/ menses
- ❒ Mid-cycle spotting
- ❒ Yeast infections
- ❒ Birth control pill (hormonal)

MENOPAUSE

Age at last menses: _____
Year changes began: _____

- ❒ Hot flashes _____x / day
- ❒ Night sweats _____x / week
- ❒ Vaginal dryness
- ❒ Loss of sex drive

Financial Policy

Payment for treatment is due at time of service. Please pay BEFORE your treatment. We accept cash, check, or credit/debit card.
In order to continue providing the best acupuncture treatments at affordable rates, The Pin Cushion has a same-day cancellation policy. Appointments that are canceled on the same day as they are scheduled and missed appointments will be charged a $15 fee payable at the next visit. If you must cancel or reschedule an appointment, please call our office or cancel online BEFORE the day of your appointment to avoid a late fee.
We understand that emergencies happen and these will be considered on an individual basis.
Thank you for respecting our time!
I agree to the above policy:

Signature _____ Date _____

Consent For Traditional Chinese Methods

I, the undersigned, hereby authorize the licensed acupuncturists of The Pin Cushion LLC to perform the following acupuncture procedures:
Acupuncture: the insertion of sterilized, disposable needles through the skin into underlying tissues at specific points on the surface of the body
Electro-acupuncture: the running of very low electrical current through one or more needles to help heal the body
Dietary and Herbal Recommendations: food and herbal supplements based on traditional Chinese medical theory.

I recognize the potential risk and benefit of these procedures as described below

Potential Risks: Although uncommon, there is a potential for acupuncture to produce some discomfort or pain at needled sites, minor bruising, or infection. It may also cause needle sickness, a broken needle, temporary discoloration of the skin, and potentially... an aggravation of symptoms existing prior to the acupuncture treatment. Clients with severe bleeding disorders or pace-makers should inform their practitioners prior to treatment.
Potential Benefits: Drugless or drug-reduced relief of presenting symptoms and the improved balance of bodily energies which may lead to prevention or elimination of the client's main complaint(s).
With this knowledge, I voluntarily consent to the above procedures, realizing that no guarantees have been given to me by the acupuncturist regarding the cure or improvement of my conditions.
I hereby release the acupuncturists of The Pin Cushion from any and all liability which may occur in connection with the above mentioned procedures, except failure to perform the procedures with the appropriate medical care. I understand that I am free to withdraw my consent and to discontinue participating in these procedures at any time.

Signature _____ Date _____