

# Acupuncture Health History Form

## Patient Information

Name \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ Province \_\_\_\_\_ Postal Code \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_ lb/kg

Sex:  Male  Female  Other Marital Status \_\_\_\_\_

Date of Birth (month/day/year) \_\_\_\_\_ Age \_\_\_\_\_

Occupation \_\_\_\_\_ Email Address \_\_\_\_\_

### Have you had acupuncture before?

No  Yes. Name of Acupuncturist \_\_\_\_\_

**Emergency Contact:** \_\_\_\_\_

**Phone Number(s):** \_\_\_\_\_

**Relationship:** \_\_\_\_\_

## Major Complaint

Primary reason for your visit today? \_\_\_\_\_

Has this condition been diagnosed by a physician, or other provider?

No  Yes, Diagnoses \_\_\_\_\_

Are you being treated for this condition by anyone else?  Yes  No

If Yes, what is the treatment? \_\_\_\_\_

Have these treatments helped?  Yes  Somewhat  Not Much  Not at all

How does this condition affect you? \_\_\_\_\_

How long have you had this condition? \_\_\_\_\_

## Personal Health History

Your general health as a child was? \_\_\_ Excellent \_\_\_ Good \_\_\_ Average \_\_\_ Poor

Did you feel safe and nurtured as a child? \_\_\_ Always \_\_\_ Usually \_\_\_ Sometimes \_\_\_ Never

**Check all the illnesses or conditions which you currently have or have had in the past:**

|   |   |   |   |
|---|---|---|---|
| <input type="checkbox"/> AIDs / HIV<br><input type="checkbox"/> Alcoholism<br><input type="checkbox"/> Allergies<br><input type="checkbox"/> Antibiotics Use<br><input type="checkbox"/> Asthma<br><input type="checkbox"/> Bleed Easily<br><input type="checkbox"/> Cancer<br><input type="checkbox"/> Chicken Pox<br><input type="checkbox"/> Diabetes<br><input type="checkbox"/> Drug Abuse | <input type="checkbox"/> Eating Disorders<br><input type="checkbox"/> Epilepsy<br><input type="checkbox"/> Glaucoma<br><input type="checkbox"/> Heart Disease<br><input type="checkbox"/> Hepatitis<br><input type="checkbox"/> High Blood Pressure<br><input type="checkbox"/> High Fevers<br><input type="checkbox"/> Hyperthyroid<br><input type="checkbox"/> Hypothyroid<br><input type="checkbox"/> Jaundice | <input type="checkbox"/> Kidney Disease<br><input type="checkbox"/> Measles<br><input type="checkbox"/> Meningitis<br><input type="checkbox"/> Mental Illness<br><input type="checkbox"/> Multiple Sclerosis<br><input type="checkbox"/> Mumps<br><input type="checkbox"/> Obesity<br><input type="checkbox"/> Pneumonia<br><input type="checkbox"/> Polio<br><input type="checkbox"/> Other _____<br>_____ | <input type="checkbox"/> Rheumatic Fever<br><input type="checkbox"/> Scarlet Fever<br><input type="checkbox"/> Sexually Transmitted Disease<br><input type="checkbox"/> Stroke<br><input type="checkbox"/> Tuberculosis<br><input type="checkbox"/> Typhoid Fever<br><input type="checkbox"/> Ulcers<br><input type="checkbox"/> Vascular Disease |
|---|---|---|---|

Are you taking Coumadin or Warfarin?  Yes  No

Do you have a pacemaker?  Yes  No      Do you have seizures?  Yes  No

Do you currently have any infectious diseases?  Yes  No  Possibly

If yes, please identify:  HIV / AIDs  Hepatitis B  Hepatis C  Flu/ Cold  Streptococcus  
 Mononucleosis  Tuberculosis  Other \_\_\_\_\_

Known or suspected allergies: \_\_\_\_\_

## Personal Health Inventory

Please put a check mark (✓) by the symptoms that you have now.

Place an (**\***) next to the ones you have noticed within the last three months.

| Qi, Blood, Yin, Yang   |  |
|--|--|
| <input type="checkbox"/> Dry Skin<br><input type="checkbox"/> Fatigue<br><input type="checkbox"/> Feverish in the afternoon or flushes<br><input type="checkbox"/> General weakness<br><input type="checkbox"/> Heat sensations in hands, feet, chest<br><input type="checkbox"/> Insomnia<br><input type="checkbox"/> Mental confusion<br><input type="checkbox"/> Night sweats | <input type="checkbox"/> Palpitations<br><input type="checkbox"/> Restlessness<br><input type="checkbox"/> Sores on tip of tongue<br><input type="checkbox"/> Speech problems<br><input type="checkbox"/> Sweats easily<br><input type="checkbox"/> Thirst at night<br><input type="checkbox"/> You feel worse after exercise<br><input type="checkbox"/> You see floating black spots |

| <b>Gastrointestinal Conditions</b>   |   |
|--|---|
| <input type="checkbox"/> Nausea<br><input type="checkbox"/> Diarrhea<br><input type="checkbox"/> Undigested food in stools<br><input type="checkbox"/> Hemorrhoids<br><input type="checkbox"/> Vomiting<br><input type="checkbox"/> Constipation<br><input type="checkbox"/> IBS<br><input type="checkbox"/> Gastritis<br><input type="checkbox"/> Acid regurgitation<br><input type="checkbox"/> Laxative use<br><input type="checkbox"/> Stomach cramps<br><input type="checkbox"/> Enteritis<br><input type="checkbox"/> Ulcerative colitis   | <input type="checkbox"/> Gas<br><input type="checkbox"/> Black stools<br><input type="checkbox"/> Itchy anus<br><input type="checkbox"/> Hard stools<br><input type="checkbox"/> Hiccup<br><input type="checkbox"/> Blood in stools<br><input type="checkbox"/> Burning anus<br><input type="checkbox"/> Bad breath<br><input type="checkbox"/> Bloating after meals<br><input type="checkbox"/> Mucus in stools<br><input type="checkbox"/> Rectal pain<br><input type="checkbox"/> Gurgling sounds<br><input type="checkbox"/> Intestinal cramping<br><input type="checkbox"/> Loose stools   |
| <b>Head, Eyes, Nose and Throat</b>   |   |
| <input type="checkbox"/> Glasses<br><input type="checkbox"/> Blurred vision<br><input type="checkbox"/> TMJ<br><input type="checkbox"/> Excessive saliva<br><input type="checkbox"/> Eye strain<br><input type="checkbox"/> Night blindness<br><input type="checkbox"/> Gum disease<br><input type="checkbox"/> Sinus problems<br><input type="checkbox"/> Red eyes<br><input type="checkbox"/> Glaucoma<br><input type="checkbox"/> Sore gums<br><input type="checkbox"/> Clear throat often<br><input type="checkbox"/> Itchy eyes<br><input type="checkbox"/> Cataracts<br><input type="checkbox"/> Bleeding gums<br><input type="checkbox"/> Migraines<br><input type="checkbox"/> Concussions | <input type="checkbox"/> Recurrent sore throat<br><input type="checkbox"/> Spots in eyes<br><input type="checkbox"/> Grinding teeth<br><input type="checkbox"/> Sores on lips<br><input type="checkbox"/> Swollen glands<br><input type="checkbox"/> “Floaters” in vision<br><input type="checkbox"/> Soft teeth<br><input type="checkbox"/> Sores on tongue<br><input type="checkbox"/> Lumps in throat<br><input type="checkbox"/> Poor vision<br><input type="checkbox"/> Multiple cavities<br><input type="checkbox"/> Dry mouth<br><input type="checkbox"/> Enlarged thyroid<br><input type="checkbox"/> Nose bleeds<br><input type="checkbox"/> Ringing in ears<br><input type="checkbox"/> Poor hearing<br><input type="checkbox"/> Earaches<br><input type="checkbox"/> Headaches |
| <b>Respiratory Conditions</b>  |   |
| <input type="checkbox"/> Feeling short of breath<br><input type="checkbox"/> Lightheaded<br><input type="checkbox"/> Fast heartbeat<br><input type="checkbox"/> Orthostatic hypotension<br><input type="checkbox"/> Difficulty breathing lying down  | <input type="checkbox"/> Chest Pain<br><input type="checkbox"/> Palpitations<br><input type="checkbox"/> Phlebitis<br><input type="checkbox"/> Productive cough with (circle all that apply)<br>A lot of sputum/ Sticky sputum/<br>Clear sputum/ Very little sputum/<br>Green sputum/ Blood in sputum   |

| Skin and Hair Conditions                         |  |   |
|--|--|---|
| <input type="checkbox"/> Rashes                  | <input type="checkbox"/> Alopecia/hair loss          |   |
| <input type="checkbox"/> Eczema                  | <input type="checkbox"/> Ulcerations                 |   |
| <input type="checkbox"/> Dandruff                | <input type="checkbox"/> Shingles                    |   |
| <input type="checkbox"/> Premature grey hair     | <input type="checkbox"/> Fungal infections           |   |
| <input type="checkbox"/> Hives                   | <input type="checkbox"/> Brittle hair                |   |
| <input type="checkbox"/> Psoriasis               | <input type="checkbox"/> Dry skin                    |   |
| <input type="checkbox"/> Itchy skin              | <input type="checkbox"/> Oily skin Acne              |   |
|  | <input type="checkbox"/> Recurrent sore throat       |   |
| Cardiovascular Conditions                        |  |   |
| <input type="checkbox"/> Chest pain              | <input type="checkbox"/> Low blood pressure          |   |
| <input type="checkbox"/> Edema                   | <input type="checkbox"/> Palpitations                |   |
| <input type="checkbox"/> High blood pressure     | <input type="checkbox"/> Stroke                      |   |
| <input type="checkbox"/> Insomnia                | <input type="checkbox"/> Varicose veins              |   |
| <input type="checkbox"/> Fainting                | <input type="checkbox"/> Lightheaded                 |   |
| <input type="checkbox"/> Fast heartbeat          | <input type="checkbox"/> Slow heartbeat              |   |
| <input type="checkbox"/> Orthostatic hypotension | <input type="checkbox"/> Irregular heartbeat         |   |
| <input type="checkbox"/> Heart attack            | <input type="checkbox"/> Phlebitis                   |   |
| Genito-urinary Conditions                        |  |   |
| <input type="checkbox"/> Painful urination       | <input type="checkbox"/> Clear urine                 |   |
| <input type="checkbox"/> Cloudy urination        | <input type="checkbox"/> Frequent bladder infections |   |
| <input type="checkbox"/> Dark yellow urine       | <input type="checkbox"/> Frequent kidney infections  |   |
| <input type="checkbox"/> Burning urination       | <input type="checkbox"/> Urinary incontinence        |   |
| <input type="checkbox"/> Frequent urination      | <input type="checkbox"/> Retention of urine          |   |
| <input type="checkbox"/> Scanty urination        | <input type="checkbox"/> Copious urination           |   |
| <input type="checkbox"/> Light yellow urine      | <input type="checkbox"/> Urination at night          |   |
| Neuropsychological Conditions                    |  |   |
| <input type="checkbox"/> Seizures                | <input type="checkbox"/> ADHD                        | <input type="checkbox"/> Poor memory          |
| <input type="checkbox"/> Tics                    | <input type="checkbox"/> Tingling                    | <input type="checkbox"/> Irritability         |
| <input type="checkbox"/> Anxiety                 | <input type="checkbox"/> Depression                  | <input type="checkbox"/> Trigeminal neuralgia |
| <input type="checkbox"/> Abuse survivor          | <input type="checkbox"/> Easily stressed             | <input type="checkbox"/> Bell's palsy         |
| <input type="checkbox"/> Numbness                | <input type="checkbox"/> Parkinson's                 | <input type="checkbox"/> Fainting             |

| <b>Medications:</b> <i>Please list medications, herbal supplements and vitamins you are currently taking.</i> |
|---|
|   |
|   |
|   |
|   |

## Family History

How do you feel about the following areas of your life in the past month?

Significant Other Great Good Fair Poor N/A Comments \_\_\_\_\_

Family Great Good Fair Poor N/A Comments \_\_\_\_\_

Self Great Good Fair Poor Comments \_\_\_\_\_

### Check illnesses which have occurred in any of your blood relatives:

Alcoholism  Cancer  Heart Disease  Mental Illness

Allergies  Diabetes  High Blood Pressure  Obesity

Bleed easily  Epilepsy  Kidney Disease  Stroke

Other \_\_\_\_\_

## Females Only

Are you pregnant?  Yes. How many months? \_\_\_\_\_  No  Trying  Maybe

Method of birth control? \_\_\_\_\_

Age of First Menses \_\_\_\_\_ Date of Last Menses \_\_\_\_\_ Age of Menopause \_\_\_\_\_

Typical Length of Menses (Days You Bleed) \_\_\_\_\_

Typical Length of Cycle (From the 1<sup>st</sup> Day of Cycle to 1<sup>st</sup> Day to the Next) \_\_\_\_\_

Number of: Pregnancies \_\_\_\_\_ Births \_\_\_\_\_ Abortions \_\_\_\_\_ Miscarriages \_\_\_\_\_

Hysterectomy  Yes  Partial  Complete Date \_\_\_\_\_

### Check all that apply to you:

Scanty Flow  Painful periods  Low Libido

Heavy Flow  Breast Tenderness  Excessive Libido

Clotting  Breast Lumps  Painful Intercourse

Vaginal Discharge  Nipple Discharge  Infertility

Abnormal Pap Smear  Fibrocystic Breasts  Fibroids

Menopausal Symptoms  Bleeding Between Cycles  Endometriosis

Premenstrual Problems  Irregular Cycles  Ovarian Cysts

Sexually Transmitted Disease: \_\_\_\_\_

Other \_\_\_\_\_

## Males Only

### Check all that apply to you:

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Low Libido                          | <input type="checkbox"/> Seminal Emissions     | <input type="checkbox"/> Prostate Problems  |
| <input type="checkbox"/> Excessive Libido                    | <input type="checkbox"/> Premature Ejaculation | <input type="checkbox"/> Testicular Pain    |
| <input type="checkbox"/> Impotence                           | <input type="checkbox"/> Painful Intercourse   | <input type="checkbox"/> Testicular Redness |
| <input type="checkbox"/> Vasectomy, Date _____               | <input type="checkbox"/> Testicular Swelling   |   |
| <input type="checkbox"/> Sexually Transmitted Disease: _____ |  |   |
| <input type="checkbox"/> Other _____                         |  |   |

## Lifestyle

### How would you rate the following areas of your health in the past month?

**Digestion**     Great    Good    Fair    Poor    Comments \_\_\_\_\_

**Stools**         Great    Good    Fair    Poor    Comments \_\_\_\_\_

How many times per day? \_\_\_\_\_ Do they feel complete?  Yes  No

Stool consistency?  Loose    Formed    Hard to Pass    Other \_\_\_\_\_

What is the color of your stools? \_\_\_\_\_

Is there blood in your stools?  Yes  No    How often? \_\_\_\_\_

**Urination**     Great    Good    Fair    Poor    Comments \_\_\_\_\_

How many times per day? \_\_\_\_\_    What color is your urine? \_\_\_\_\_

After you've gone to sleep do you get up to urinate?    Yes  No    How often? \_\_\_\_\_

**Appetite**         Great    Good    Fair    Poor    Comments \_\_\_\_\_

**Diet**             Great    Good    Fair    Poor    Comments \_\_\_\_\_

Are you vegetarian or vegan?    No  Yes: for how long? \_\_\_\_\_

### Do you have any of the following habits?

Caffeinated Drinks     No  Yes. How much? (e.g. 2/day) \_\_\_\_\_

Smoking                 No  Yes: How much? (e.g. 2/day) \_\_\_\_\_

Alcohol                 No  Yes: How much? (e.g. 2/day) \_\_\_\_\_

Recreational Drugs    No  Yes: Specify TYPE and How much: \_\_\_\_\_

Other (Describe)       No  Yes \_\_\_\_\_

**How do you feel about the following areas of your life in the past month?**

**Energy**     Great    Good    Fair    Poor    Comments\_\_\_\_\_

On a scale of 1 to 10? (10 is high energy) \_\_\_\_\_

**Sleep**     Great    Good    Fair    Poor    Comments\_\_\_\_\_

Hours per night? \_\_\_\_\_ Do you wake feeling rested?  Yes  No

**Sex Life**     Great    Good    Fair    Poor    Comments\_\_\_\_\_

**School**     Great    Good    Fair    Poor    Comments\_\_\_\_\_

**Exercise**     Great    Good    Fair    Poor    Comments\_\_\_\_\_

How often? \_\_\_\_\_ What kind? \_\_\_\_\_

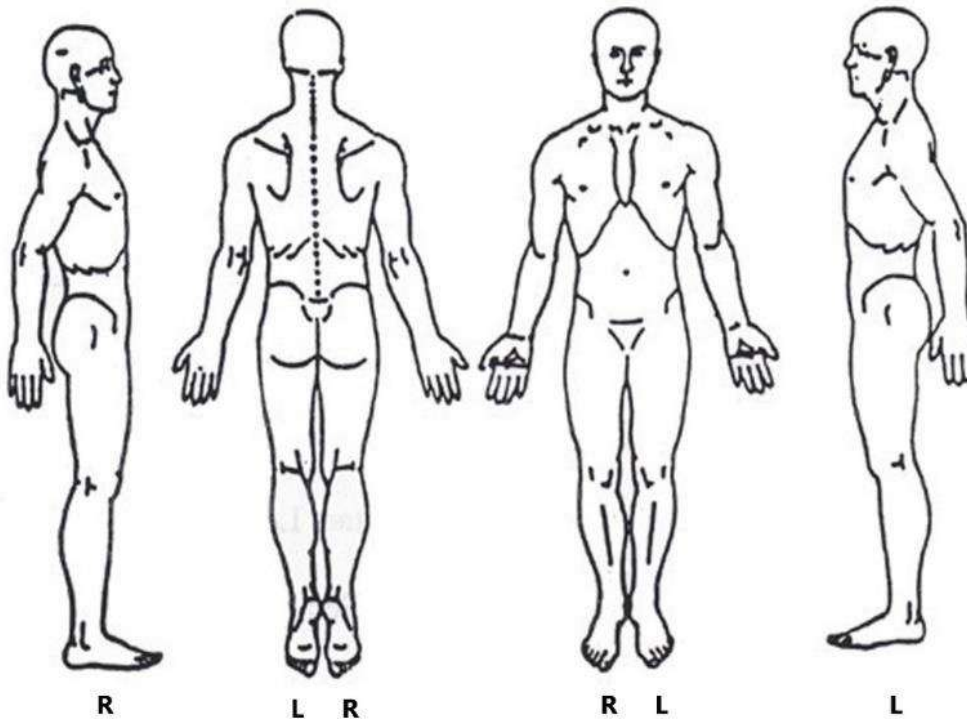
How would you rate your stress level on a scale of 1 to 10? (10 is high stress)\_\_\_\_\_

How well do you feel you handle your stress?     Great    Good    Fair    Poor

**Pain**

Please answer the following questions if you have pain.

**Indicate on the diagram your areas of pain**



How long have you had this pain? \_\_\_\_\_

Describe the onset of your pain.

---

---

---

---

On a scale of 1-10, how intense is your pain? (10 = intense) \_\_\_\_\_

What does your pain feel like? **Check all that apply.**

- |                                   |   |                                      |
|-----------------------------------|---|--------------------------------------|
| <input type="checkbox"/> Dull     | <input type="checkbox"/> Cramping       | <input type="checkbox"/> Fixed       |
| <input type="checkbox"/> Sharp    | <input type="checkbox"/> Burning        | <input type="checkbox"/> Moves About |
| <input type="checkbox"/> Stabbing | <input type="checkbox"/> Constant       |                                      |
| <input type="checkbox"/> Achy     | <input type="checkbox"/> Comes-and-goes |                                      |

Does the pain radiate?  No  Yes: where? \_\_\_\_\_

What relieves the pain? **Check all that apply.**

- Ice  Heat  Rest  Movement  Pressure  Moisture  Massage  Nothing  
 Other \_\_\_\_\_

What aggravates the pain? **Check all that apply.**

- Ice  Heat  Rest  Movement  Pressure  Moisture  Massage  Nothing  
 Other \_\_\_\_\_

Have you had any other treatments for this pain? **Please identify and describe.**

---

---

Describe any concerns you have regarding your comfort and safety during an acupuncture treatment such as: needle phobia, bleeding disorders (e.g. haemophilia), pace maker, medication pump, blood pressure, infections, compromised skin (e.g. lesions, cuts, burns).

---

---

---

---



## **Informed Consent for Acupuncture Treatment**

I hereby agree and consent to the performance of acupuncture and other traditional Chinese Medicine procedures. I understand that such procedures may include, but are not limited to acupuncture, acupressure, moxibustion, cupping & gua-sha (dermal friction technique), infrared heat lamp, laser therapy, breathing techniques, exercise therapy, Tui-Na (Chinese massage), Chinese herbal medicine, and nutritional counseling based on traditional Chinese medical theory.

Occasionally there may be increased soreness at the sites of treatment on the day of, or day following treatment. I have been informed that in all acupuncture treatments only sterile, disposable needles are used according to the Clean Needle Technique protocol, to ensure the safest acupuncture treatment possible.

I have been informed that acupuncture is a safe method of treatment, but may have some side effects, including bruising, numbness or tingling, dizziness or fainting, minor swelling, bleeding, hematoma may occur at the site of insertion and may last a few days. A sensation of light-headedness may occur after acupuncture treatment. I will immediately notify the acupuncturist if I experience any symptoms or problems. I understand that I should not make significant movements while the needles are being inserted, manipulated, retained, or removed.

I am relying on the TCM practitioner to exercise judgment during the course of my treatment, trusting that, based upon facts then known, this treatment plan is appropriate and in my best interests. I understand that acupuncture and other Oriental Medicine procedures are not substitutes for treatment by my medical doctor. Also, at any given time throughout the treatment, I may request the practitioner to stop, modify or change the treatment plan.

I state that I do not have the following conditions: pregnancy, bleeding disorders, pacemaker, local infections; or am currently taking anticoagulants.

By voluntarily signing below I, \_\_\_\_\_, hereby certify that I have read this entire form, have been told about the risks and benefits of acupuncture and other procedures, and have had an opportunity to ask questions and that I consent to treatment with the modalities described above. I intend this consent form to cover the entire course of treatment to be performed for my present condition and for any future condition(s) for which I seek treatment.

\_\_\_\_\_  
Name (Please Print)

\_\_\_\_\_  
Signature of Patient (or legal guardian)

Date: \_\_\_\_\_

\_\_\_\_\_  
Signature of Acupuncturist

Date: \_\_\_\_\_