

Auburn Community Acupuncture HEALTH HISTORY

Date: ___ / ___ / ___

Name:				Sex:		Age:	
Address:			City:		State:		Zip Code:
Phone # that you prefer to be contacted at:		Other Phone #: Work Cell Other		Email:			
Date of Birth:		Employer:		Occupation:			
Health Care Providers:			Relationship Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Living w/partner <input type="checkbox"/> Other: _____				
Height:			Usual Blood Pressure:				
Weight:		Weight One Year Ago:		How did you hear of our clinic? <input type="checkbox"/> Friend _____ <input type="checkbox"/> ACA Website <input type="checkbox"/> Health Provider _____ <input type="checkbox"/> Flyer <input type="checkbox"/> ABWA <input type="checkbox"/> Other _____			
Are you or may you be currently pregnant?				Have you been treated by Acupuncture or Oriental Medicine Before? <input type="radio"/> No <input type="radio"/> 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

HEALTH HISTORY

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

HABITS

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

EXERCISE

Do you exercise regularly? Yes No

If so, what and how often:

DIET

Low/No Carb, Vegetarian/Vegan, Portion Control, Low Fat, Standard American

Current or past eating disorder?

MEDICATIONS

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

INJURIES & SURGERIES

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

<input type="checkbox"/> Cold hands or feet <input type="checkbox"/> Chills <input type="checkbox"/> Cold "in the bones" <input type="checkbox"/> Areas of numbness	Thirst for cold / hot drinks <input type="checkbox"/> Thirst, no desire to drink <input type="checkbox"/> Absence of thirst <input type="checkbox"/> Excessive thirst	<input type="checkbox"/> Night sweats <input type="checkbox"/> Unusual sweats When _____ am / pm Where on body _____	<input type="checkbox"/> Hot hands, feet, chest <input type="checkbox"/> Hot flashes <input type="checkbox"/> Hot in afternoon <input type="checkbox"/> Hot at night
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MOISTURE

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

DRY |-----| OILY

Where on your body?

<input type="checkbox"/> Dry skin <input type="checkbox"/> Dry hair <input type="checkbox"/> Dry eyes <input type="checkbox"/> Dry brittle nails	<input type="checkbox"/> Dry mouth <input type="checkbox"/> Dry lips <input type="checkbox"/> Dry throat <input type="checkbox"/> Dry nose / Nosebleeds	<input type="checkbox"/> Edema / Swelling _____ <input type="checkbox"/> Rashes _____ <input type="checkbox"/> Itching _____ <input type="checkbox"/> Dandruff	<input type="checkbox"/> Oily skin <input type="checkbox"/> Oily hair <input type="checkbox"/> Pimples <input type="checkbox"/> Weight gain / loss
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DIGESTION

DIARRHEA |-----| CONSTIPATION

BM: How often? _____ x / every _____ days Stools keep shape? <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Alternating diarrhea & constipation (IBS) <input type="checkbox"/> Indigestion	<input type="checkbox"/> Gas <input type="checkbox"/> Bloating <input type="checkbox"/> Belching <input type="checkbox"/> Poor appetite	<input type="checkbox"/> Nausea / Vomiting <input type="checkbox"/> Bad breath <input type="checkbox"/> Heartburn <input type="checkbox"/> Excessive hunger	<input type="checkbox"/> Dry Stools <input type="checkbox"/> Difficult to pass <input type="checkbox"/> Tired after BM <input type="checkbox"/> Foul smelling stools
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ENERGY

LOW |-----| HIGH

<input type="checkbox"/> Sudden energy drop Time of day: _____ am / pm <input type="checkbox"/> Energy drop after eating <input type="checkbox"/> Fatigue	<input type="checkbox"/> Dependence on caffeine / stimulants <input type="checkbox"/> Wired / ungrounded feeling <input type="checkbox"/> Body / Limbs feel heavy <input type="checkbox"/> Body / Limbs feel weak	<input type="checkbox"/> Shortness of breath <input type="checkbox"/> Heart Palpitations <input type="checkbox"/> Blood pressure High / Low <input type="checkbox"/> Bleed / Bruise easy	<input type="checkbox"/> Hard to concentrate <input type="checkbox"/> Poor memory <input type="checkbox"/> Dizziness / lightheaded <input type="checkbox"/> Headaches _____ x / week
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SLEEP

Hours per night _____

Difficulty falling asleep

Wake _____ x / night @ _____ am / pm

Wake to urinate: How often? _____

Disturbing dreams

Restless sleep

Not rested upon waking

EMOTIONS

What emotion(s) dominate your experience?

<input type="checkbox"/> Anger <input type="checkbox"/> Irritability <input type="checkbox"/> Anxiety <input type="checkbox"/> Worry <input type="checkbox"/> Obsessive thinking <input type="checkbox"/> Sadness	<input type="checkbox"/> Grief <input type="checkbox"/> Depression <input type="checkbox"/> Joy <input type="checkbox"/> Fear <input type="checkbox"/> Timid / shy <input type="checkbox"/> Indecision
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EYES, EARS, NOSE, THROAT

<input type="checkbox"/> Poor vision <input type="checkbox"/> Night blindness <input type="checkbox"/> Red eyes <input type="checkbox"/> Itchy eyes <input type="checkbox"/> Spots in front of eyes <input type="checkbox"/> Sinus congestion <input type="checkbox"/> Phlegm (color _____)	<input type="checkbox"/> Poor hearing <input type="checkbox"/> Ringing in ears <input type="checkbox"/> Excess earwax <input type="checkbox"/> Sore throat <input type="checkbox"/> Dental problems <input type="checkbox"/> Mouth sores <input type="checkbox"/> Cough
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MENSES

Age at first menses: _____

Length of full cycle: _____ days (i.e. 28)

Length of menses: _____ days (i.e. 3-4)

Last menses start date: ____ / ____

of pregnancies: _____

of births: _____ premature _____

of abortions / miscarriages: _____

MENOPAUSE

Age at last menses: _____

Year changes began: _____

<input type="checkbox"/> Heavy periods <input type="checkbox"/> Light periods <input type="checkbox"/> Painful periods <input type="checkbox"/> Irregular periods <input type="checkbox"/> Changes in body/ psyche prior to menstruation (PMS)	<input type="checkbox"/> Cramps <input type="checkbox"/> Before bleeding <input type="checkbox"/> First day <input type="checkbox"/> During period <input type="checkbox"/> Clots <input type="checkbox"/> Breast tenderness	<input type="checkbox"/> Hot flashes _____ x / day <input type="checkbox"/> Night sweats _____ x / week <input type="checkbox"/> Vaginal dryness <input type="checkbox"/> Loss of sex drive <input type="checkbox"/> Mood changes <input type="checkbox"/> Fatigue w/ menses <input type="checkbox"/> Digestive changes w/ menses <input type="checkbox"/> Mid-cycle spotting <input type="checkbox"/> Yeast infections <input type="checkbox"/> Birth control pill (hormonal)
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Auburn Community Acupuncture
HEALTH HISTORY for MEN



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

- | | | | |
|--|---|---|---|
| <input type="checkbox"/> Cold hands or feet | Thirst for cold / hot drinks | <input type="checkbox"/> Night sweats | <input type="checkbox"/> Hot hands, feet, chest |
| <input type="checkbox"/> Chills | <input type="checkbox"/> Thirst, no desire to drink | <input type="checkbox"/> Unusual sweats | <input type="checkbox"/> Hot flashes |
| <input type="checkbox"/> Cold "in the bones" | <input type="checkbox"/> Absence of thirst | When _____ am / pm | <input type="checkbox"/> Hot in afternoon |
| <input type="checkbox"/> Areas of numbness | <input type="checkbox"/> Excessive thirst | Where on body _____ | <input type="checkbox"/> Hot at night |

MOISTURE

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

DRY

OILY

- | | | | |
|--|--|---|---|
| <input type="checkbox"/> Dry skin | <input type="checkbox"/> Dry mouth | <input type="checkbox"/> Edema / Swelling _____ | <input type="checkbox"/> Oily skin |
| <input type="checkbox"/> Dry hair | <input type="checkbox"/> Dry lips | <input type="checkbox"/> Rashes _____ | <input type="checkbox"/> Oily hair |
| <input type="checkbox"/> Dry eyes | <input type="checkbox"/> Dry throat | <input type="checkbox"/> Itching _____ | <input type="checkbox"/> Pimples |
| <input type="checkbox"/> Dry brittle nails | <input type="checkbox"/> Dry nose / Nosebleeds | <input type="checkbox"/> Dandruff | <input type="checkbox"/> Weight gain / loss |
- Where on your body?

DIGESTION

DIARRHEA

CONSTIPATION

- | | | | |
|--|--|--|---|
| BM: How often? _____ x / every _____ days | <input type="checkbox"/> Gas | <input type="checkbox"/> Nausea / Vomiting | <input type="checkbox"/> Dry Stools |
| Stools keep shape? <input type="checkbox"/> Y <input type="checkbox"/> N | <input type="checkbox"/> Bloating | <input type="checkbox"/> Bad breath | <input type="checkbox"/> Difficult to pass |
| <input type="checkbox"/> Alternating diarrhea & constipation (IBS) | <input type="checkbox"/> Belching | <input type="checkbox"/> Heartburn | <input type="checkbox"/> Tired after BM |
| <input type="checkbox"/> Indigestion | <input type="checkbox"/> Poor appetite | <input type="checkbox"/> Excessive hunger | <input type="checkbox"/> Foul smelling stools |

ENERGY

LOW

HIGH

- | | | | |
|---|--|--|---|
| <input type="checkbox"/> Sudden energy drop | <input type="checkbox"/> Dependence on caffeine / stimulants | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Hard to concentrate |
| Time of day: _____ am / pm | <input type="checkbox"/> Wired / ungrounded feeling | <input type="checkbox"/> Heart Palpitations | <input type="checkbox"/> Poor memory |
| <input type="checkbox"/> Energy drop after eating | <input type="checkbox"/> Body / Limbs feel heavy | <input type="checkbox"/> Blood pressure High / Low | <input type="checkbox"/> Dizziness / lightheaded |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Body / Limbs feel weak | <input type="checkbox"/> Bleed / Bruise easy | <input type="checkbox"/> Headaches _____ x / week |

SLEEP

- # Hours per night _____
- Difficulty falling asleep
 - Wake _____ x / night @ _____ am / pm
 - Wake to urinate How often? _____
 - Disturbing dreams
 - Restless sleep
 - Not rested upon waking

EMOTIONS

What emotion(s) dominate your experience?

- | | |
|---|--------------------------------------|
| <input type="checkbox"/> Anger | <input type="checkbox"/> Grief |
| <input type="checkbox"/> Irritability | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Joy |
| <input type="checkbox"/> Worry | <input type="checkbox"/> Fear |
| <input type="checkbox"/> Obsessive thinking | <input type="checkbox"/> Timid / shy |
| <input type="checkbox"/> Sadness | <input type="checkbox"/> Indecision |

EYES, EARS, NOSE, THROAT

- | | |
|---|--|
| <input type="checkbox"/> Poor vision | <input type="checkbox"/> Poor hearing |
| <input type="checkbox"/> Night blindness | <input type="checkbox"/> Ringing in ears |
| <input type="checkbox"/> Red eyes | <input type="checkbox"/> Excess earwax |
| <input type="checkbox"/> Itchy eyes | <input type="checkbox"/> Sore throat |
| <input type="checkbox"/> Spots in front of eyes | <input type="checkbox"/> Dental problems |
| <input type="checkbox"/> Sinus congestion | <input type="checkbox"/> Mouth sores |
| <input type="checkbox"/> Phlegm (color _____) | <input type="checkbox"/> 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