NAPA ACUPUNCTURE PRACTICE

Health History Questionnaire and Registration

PATIENT INFORMATION	CONTACT INFORMATION
Date____	Home phone __(_____)____________________________
Name____	Work phone ___(_____)___________________________
Address______________________________________	Other/cell phone _(_____)_________________________
City State Zip_________________________________	Email ____
Age___________ Birthdate ____________________	
Occupation __________________________________	Another person we may contact if needed:
Company name _______________________________	Name ____
Primary physician ____________________________	Relationship______________________________________
Primary Physician phone_(_____)_______________	Home phone _(_____)________________________________
How did you hear about us? ____________________ ____	Work phone__(_____)________________________________

HEALTH HISTORY

Circle/Underline answers.

What are your primary concerns for coming in for treatment?

1- ____

2 - ____

3 - ____

Hard fall asleep/stay asleep/vivid dreams? Wake rested?

____

How is your digestion? Gas/ bloating/ reflux?

____

List medications or food supplements you are taking.

____

____

List serious **allergies**, illnesses, accidents or surgeries.

____

____

Check illnesses that have occurred in blood relatives.

☐ Diabetes ☐ High blood pressure ☐ Stroke
☐ Cancer ☐ Heart disease ☐ Kidney disease

Check symptoms you have or have had in the last year:

- ☐ Depression
- ☐ Difficulty in focusing
- ☐ Dizziness
- ☐ Easily startled
- ☐ Excess worry
- ☐ Excess anger
- ☐ Excess fear
- ☐ Fatigue/tiredness
- ☐ Headaches
- ☐ Loss of sleep/poor sleep
- ☐ Loss or gain of weight
- ☐ Nervousness/irritability
- ☐ Overwhelmed by life

Check conditions you have or have had in the past:

- ☐ AIDS
- ☐ Allergies
- ☐ Anemia
- ☐ Arthritis
- ☐ Bleeding disorders
- ☐ Breast lump
- ☐ Cancer --Location_________________________
- ☐ Diabetes

About how long has it been since you have had a complete physical exam? _______________________________

HEALTH HISTORY…CONTINUED

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Check symptoms you have or have had in the last year:

MUSCLE/JOINT/BONES
- ☐ Tremors or Cramps
- ☐ Swollen joints

Pain, weakness, swelling, numbness in:
- ☐ Arms
- ☐ Legs
- ☐ Hips
- ☐ Back
- ☐ Feet
- ☐ Neck
- ☐ Hands
- ☐ Shoulders
- ☐ Other___________________

EYES/EAR/NOSE/THROAT/RESPIRATORY
- ☐ Asthma/wheezing/difficulty breathing
- ☐ Blurred or failing vision
- ☐ Earache
- ☐ Enlarged glands
- ☐ Eye pain
- ☐ Frequent colds
- ☐ Hay fever
- ☐ Hoarseness
- ☐ Gum trouble
- ☐ Nose bleeds
- ☐ Loss of hearing
- ☐ Persistent cough
- ☐ Ringing in ears
- ☐ Sinus problems

SKIN
- ☐ Boils
- ☐ Bruise easily
- ☐ Dry skin
- ☐ Itching/rash
- ☐ Sensitive skin
- ☐ Sore won't heal
- ☐ Sweats—where?

GENITO/URINARY
- ☐ Blood/pus in urine
- ☐ Frequent urination
- ☐ Inability to control urine
- ☐ Kidney infection/stones
- ☐ Lowered libido

CARDIOVASCULAR
- ☐ Chest pain
- ☐ Hardening of arteries
- ☐ High or low blood pressure
- ☐ Pace Maker?
- ☐ Poor circulation
- ☐ Previous heart attack
- ☐ Rapid/irregular heart beat
- ☐ Swelling of ankles

GASTROINTESTINAL
- ☐ Belching, gas or bloating
- ☐ Colon trouble
- ☐ Constipation
- ☐ Diarrhea
- ☐ Difficulty swallowing
- ☐ Distention of abdomen
- ☐ Excessive hunger
- ☐ Gall bladder trouble
- ☐ Hemorrhoids (piles)
- ☐ Indigestion
- ☐ Nausea
- ☐ Pain over stomach
- ☐ Poor appetite
- ☐ Vomiting

*****FOR MEN ONLY***
- ☐ Erection difficulties
- ☐ Penis discharge
- ☐ Prostate trouble

*****FOR WOMEN ONLY***
- ☐ Bleeding between periods
- ☐ Clots in menses
- ☐ Excessive menstrual flow
- ☐ Extreme menstrual pain
- ☐ Irregular cycle
- ☐ Menopausal symptoms
- ☐ PMS
- ☐ Previous miscarriage
- ☐ Scanty menstrual flow

Could you be pregnant? _____________

SIGNATURE

The information on this form is correct to the best of my knowledge.

Signature____ Date ________________________