The Healing Point, LLC
Cindy Lawrence, M.AOM, L.Ac.
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Health History

Full Name:			**Date:**
Date of Birth:	**Age:**	**Height:**	**Weight:**
Address:	**City/State:**		**Zip:**
Home Phone:	**Work Phone:**		
Cell Phone:	**Email:**		
Emergency Contact:	**Emergency Phone:**		
Occupation:	**Employer:**		

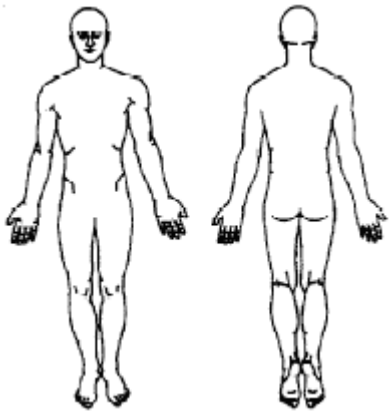
Referred by: _____
Have you had acupuncture before? □ yes □ no
If yes, for what condition and when? _____

Please list the concern(s) that have brought you here today:
Date of onset
_____ _____
_____ _____
_____ _____
_____ _____

Have you previously been treated for any of these symptoms? □ yes □ no
What was the result? _____
What time of the day do you feel the worst? _____ Best? _____

Please mark the areas of discomfort or pain on the figures below using the symbol that best describes what you are feeling.

+++ sharp/stabbing ooo pins and needles vvv dull or aching / / / numbness



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Are you currently under the care of a medical doctor or other health care provider? □ yes □ no
Name of doctor: _____ Phone #: _____
Please list any medications you are taking.
Medication Dosage Reason Date Started
_____
_____
_____

What dietary supplements and/or herbs do you regularly take? _____
_____
Please list any allergies: _____
Have you ever had an overnight stay in a hospital or a surgical procedure of any kind?
Event: _____ Date: _____
Event: _____ Date: _____

Please describe any that apply.

	Personal History	**Family History**
Heart disease		
High blood pressure		
Cancer		
Autoimmune disorder		
Arthritis		
Diabetes		
Congenital disorder		
Thyroid disorder		
Kidney disease		
Liver disease		
Respiratory disorder		
Neurological disorder		
Gastrointestinal disorder		
Genitourinary condition		
Anxiety/Depression		
Seizure disorder		
Other (please specify)		

What is your stress level on a scale of 1-10 (1 minimum, 10 maximum)? _____
Do you sleep well? □ yes □ no What are your normal sleeping hours ? _____ to _____
Please check the boxes which best describe your digestion:
□ Good □ Indigestion □ Constipation □ Diarrhea □ Poor appetite
□ Cravings (type) _____

Please describe your typical diet:
Breakfast: _____
Lunch: _____
Dinner: _____
Snacks: _____

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How many caffeinated drinks do you have per week? _____
How many alcoholic drinks do you have per week? _____
Do you smoke? □ yes □ no If so, how many per day? _____
Do you exercise? □ yes □ no If yes, please describe activity: _____
How many days per week? _____ How many minutes per session? _____

Please check any of the following that apply.

□ Low back pain and/or weakness
□ Achy and/or weak knees
□ Frequent urination
□ Incontinence
□ Dark, scanty urine
□ Night sweats
□ Hot flashes
□ Hot hands and feet
□ Vaginal dryness
□ Scanty cervical mucus

□ Cold hands and feet
□ Cold feeling of lower back and knees
□ Weak legs
□ Night time urination
□ Copious, clear urination
□ Early morning loose bowel movement
□ Water retention or edema of legs
□ Lassitude
□ Lower back pain premenstrually
□ Profuse vaginal discharge

□ Depression/irritability
□ Fluctuation of mental state
□ Sighing
□ Abdominal distension
□ Borborygmi

□ Hypochondriac pain
□ Tinnitus
□ PMS
□ Irregular menstruation
□ Painful periods

□ Anxiety
□ Insomnia
□ Restlessness

□ Heart palpitations
□ Disturbing dreams
□ Fidgeting

□ Low energy/fatigue
□ Fatigue after eating
□ Bloating after eating
□ Loose stools
□ Bruise easily
□ Crave sweets
□ Uterine prolapsed

□ Acid reflux
□ Sour belching
□ Mouth sores
□ Nausea/vomiting
□ Constipation
□ Increased appetite
□ Spotting before menses

□ Asthma
□ Allergies
□ Shortness of breath

□ Prone to catching colds
□ Chronic sinus congestion
□ Dry skin

□ Pale complexion
□ Dry and flakey skin
□ Brittle finger and toenails
□ Thin, dry and/or brittle hair
□ Scanty and/or late menses

□ Dark complexion
□ Varicose or spider veins
□ Hemangiomas
□ Numbness of extremities
□ Mid-cycle pain

□ Heaviness of body and head
□ Sticky taste in mouth
□ Generalized joint aches
□ Excess weight

□ Prone to yeast infections
□ Difficult and cloudy urination
□ White sticky vaginal discharge
□ Fibrocystic breasts

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Menstrual History

Age when menses began: _____ Date of last menstrual period: _____
How many days are your cycles? _____ How many days do you bleed? _____
On what day do you ovulate? _____
Are your periods regular? □ yes □ no
How heavy is the bleeding? □ Light □ Medium □ Heavy
What color is the blood? □ pale red □ bright red □ dark red □ purple □ brown
Are there clots? □ yes □ no If yes, what size? □ small □ large
Please check the box that best describes your period:
□ Scant, thin, red □ Heavy, dark, clotted □ Normal red flow

Do you spot between your periods? □ yes □ no
Do you experience pain during ovulation? □ yes □ no
Do you regularly get yeast infections? □ yes □ no
Do you experience chronic vaginal discharge? □ yes □ no

Do you experience PMS? □ yes □ no When? _____
What are your symptoms?
□ irritability □ bloating □ cramping □ breast tenderness □ low back pain □ headaches □ acne
□ digestive upset

Are you currently pregnant? □ yes □ no

Number of pregnancies: _____ Number of births: _____ Number of abortions: _____
Number of miscarriages: _____ Number of D & C's: _____

Date of last pap smear: _____
Have you ever had an abnormal pap smear? □ yes □ no

Have you ever had any of the following?
□ cervical biopsy □ cauterization □ conization
Have you ever been diagnosed with any of the following?
□ Chlamydia □ gonorrhea □ herpes □ syphilis □ other
When were you diagnosed? _____ Was it treated? _____

Have you ever been diagnosed with any of the following?
□ Polycystic ovary syndrome (PCOS) □ Endometriosis □ Uterine polyps
□ Uterine fibroids □ Pelvic adhesions □ Pelvic inflammatory disease □ Pelvic abnormalities

Do you experience milk or discharge from your breasts? □ yes □ no

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Fertility History

How long have you been trying to conceive? _____
Have you ever been given a diagnosis regarding the infertility? □ yes □ no
If yes, what was the diagnosis? _____

Have you ever had fertility treatments? □ yes □ no If yes, please list treatments below.
Treatment Date
_____
_____
_____
_____
_____
_____

Have you taken any fertility medications? □ yes □ no If yes, please list medication below.
Medication Date Length of time
_____
_____
_____

What fertility procedure are you currently undergoing?
_____

Have you had any tubal operations? □ yes □ no
Have you had your fallopian tubes evaluated or had a hysterosalpingogram (HSG)? □ yes □ no
If yes, what were the results? _____
Have you had your hormone levels tested? □ yes □ no If yes, what were the results?
_____

Have you ever used any type of birth control? □ yes □ no If so, what kind?
_____
When did you last use birth control? _____
How is your libido? □ low □ normal □ high
Do you use lubricants? □ yes □ no
Do you douche regularly? □ yes □ no

Have you been exposed to any known environmental toxins? □ yes □ no

Has your partner had his reproductive status evaluated by a physician? □ yes □ no

I certify that the above information is true and correct to the best of my knowledge.

Signature: _____ Date: _____