Access Acupuncture
New Patient Health History

Name: _____ Date: _____/_____/_____
(first) (middle) (last)

Address_____ City/State/Zip_____

Phone_____Email_____

Emergency Contact Name & Phone_____

Date of Birth: _____/_____/_____ Age: _____ Gender: M or F Marital status: S M D W

Successful health care and preventative medicine are only possible when the practitioner has a complete understanding of the patient physically, mentally and emotionally. Please complete this questionnaire as thoroughly as possible. Print all information and indicate areas of confusion with a question mark. Thank you.

Chief complaints Date of onset Severity of symptoms (1-10)

_____

_____

_____

_____

_____

_____

On a scale of 1-10 (10 being extremely motivated) how motivated are you to take control of the above complaints? _____

When and where did you last receive health care? _____

For what reason? _____

Primary Physician's Name and Phone #_____

Have you had Acupuncture before? Y N Herbal Medicine? Y N

If applicable, please list any foods, drugs, or medications you are hypersensitive or allergic to (please include reaction):

_____

_____

Please list any medications (prescribed and over-the-counter), vitamins, and supplements you are currently taking:

_____

_____

_____

Height: _____ **Weight:** _____ Maximum: _____ When? _____

Blood Pressure: What is your most recent blood pressure reading? _____/_____ When was this reading taken? _____

Do you have any reason to believe you may be pregnant? Y N If so, how far along are you?_____

Do you have any infectious diseases? Y N If yes, please identify: _____

Family History:

__Allergies __Arteriosclerosis __Asthma __Alcoholism __Cancer __Diabetes __Heart Disease

__High Blood Pressure __Seizures __Stroke __Other __ _____

Childhood Illness (please circle any that you have had):

Scarlet Fever /Diphtheria Rheumatic Fever Mumps Measles German Measles Chicken Pox

Immunizations (please circle any that you have had):

Polio Tetanus Rubella/Mumps/Rubella Pertussis Diphtheria Hib Hepatitis B

Others: _____

Hospitalizations and Surgeries, Imaging Studies:

Reason	When	Reason	When
_____		_____	
_____		_____	
_____		_____	

Emotional (please circle any that you experience now and underline any that you have experienced in the past):

Mood Swings Nervousness Mental Tension/Stress Anxiety Depression

Energy and Immunity (please circle any that you experience now and underline any that you have experienced in the past):

Fatigue Slow Wound Healing Chronic Infections Chronic Fatigue Syndrome

Head, Eye, Ear, Nose, and Throat (please circle any that you experience now and underline any that you have experienced in the past):

Impaired Vision	Eye Pain/Strain	Glaucoma	Glasses/Contacts	Tearing/Dryness
Impaired Hearing	Ear Ringing	Earaches	Headaches	Sinus Problems
Nose Bleeds	Frequent Sore Throats	Teeth Grinding	TMJ/Jaw Problems	Hay Fever

Respiratory (please circle any that you experience now and underline any that you have experienced in the past):

Pneumonia	Frequent Colds	Difficulty Breathing	Emphysema
Persistent Cough	Pleurisy	Asthma	Tuberculosis
Shortness of Breath	Other Respiratory Problems: _____		

Cardiovascular (please circle any that you experience now and underline any that you have experienced in the past):

Heart Disease	Chest Pain	Swelling of Ankles	High Blood Pressure	
Palpitations/Fluttering	Stroke	Heart Murmurs	Rheumatic Fever	Varicose Veins

Gastrointestinal (please circle any that you experience now and underline any that you have experienced in the past):

Bloating	Constipation	Diarrhea	Acid Reflux	Distention	Changes in BM
Ulcers	Changes in Appetite	Nausea/Vomiting	Epigastric Pain	Passing Gas	Abdominal Pain
Belching	Gall Bladder Disease	Liver Disease	Hepatitis B or C	Hemorrhoids	Pancreatitis

Other_____

Genito-Urinary Tract (please circle any that you experience now and underline any that you have experienced in the past):

Kidney Disease	Painful Urination	Frequent UTI	Frequent Urination
Kidney Stones	Impaired Urination	Blood in Urine	Frequent Urination at Night

Female Reproductive/Breasts (please circle any that you experience now and underline any that you have experienced in the past):

Irregular Cycles	Breast Lumps/Tenderness	Nipple Discharge	Heavy Flow
Vaginal Discharge	Premenstrual Problems	Clotting	Bleeding Between Cycles
Menopausal Symptoms	Difficulty Conceiving	Painful Periods	Endometriosis
Fibroids	Cysts	STD (if so, what)_____	

Menstrual/Birthing History:

1. Age of First Menses: _____	4. Birth Control Type: _____	7. # of Abortions: _____
2. # of Days of Menses: _____	5. # of Pregnancies: _____	8. # of Live Births: _____
3. Length of Cycle: _____	6. # of Miscarriages: _____	

Male Reproductive (please circle any that you experience now and underline any that you have experienced in the past):

Sexual Difficulties	Prostate Problems	Testicular Pain/Swelling	Penile Discharge
STD (if so, what)_____			

Musculoskeletal (please circle any that you experience now and underline any that you have experienced in the past):

Neck/Shoulder Pain	Low Back Pain	Muscle Spasms/Cramps	Arm Pain
Upper Back Pain	Leg Pain	Weakness	Arthritis
Mid Back Pain	Joint Pain	Osteoporosis	

Neurological (please circle any that you experience now and underline any that you have experienced in the past):

Vertigo/Dizziness	Paralysis	Numbness/Tingling	Loss of Balance	Seizures/Epilepsy

Endocrine (please circle any that you experience now and underline any that you have experienced in the past):

Hypothyroid	Hyperthyroid	Hypoglycemia	Diabetes Mellitus	Night Sweats	Feeling Hot or Cold

Other (please circle any that you experience now and underline any that you have experienced in the past):

Anemia	Cancer	Rashes	Eczema/Hives	Cold Hands/Feet	Acne

Lifestyle:

a. Do you typically eat at least three meals per day? Y N If no, how many?

_____

b. Exercise routine: _____

c. Spiritual practice (i.e. prayer, meditation, etc.)_____

d. How many hours per night do you sleep? _____ Do you wake rested? Y N

e. Occupation: _____ Employer: _____ Hours/Week: _____

Do you enjoy work? Y/N Why/Why not? _____

f. Nicotine/Alcohol/Caffeine Use:

_____

g. Have you experienced any major traumas? Y N Explain: _____

_____

Is there anything else we should know? _____

Should you need to reschedule an appointment, **24 HOURS NOTICE** is required. If you fail to notify us 24 hours in advance**, you will be charged $40 for your missed appointment**. A missed appointment is a loss for everyone. For a Monday cancellation, please call on Friday.

I understand that my case may need to be co-managed with other medical providers including my MD, DO or DC and I authorize my acupuncture provider and this office to contact them as needed.

PATIENT SIGNATURE (or Patient Representative indicating relationship)_____

DATE_____

How did you hear about us? _____

Would you like to receive our email newsletter? _____