Health History Intake Form

Please help me provide you with a complete evaluation by taking time to fill out this form carefully. All of your information is held confidential unless you sign an authorization for your records to be released.

Name	Date of Birth	Today's Date
Address	City, State, Zip	Phone (indicate cell, home, etc.)
email*	Emergency Contact	Emergency Contact Phone
Primary Physician:	Is this your first experience with Acupuncture?	How did you hear about Full Bloom Acup?

*Email address that you would like appointment reminders sent. I will not disclose your email to a third party. By providing an email address, I acknowledge that email communication is not encrypted and may not be secure.

What health concern(s) do you want to address?
When did this/these health concern(s) begin?
Do you know the cause of your health concern(s)?
Have you seen a doctor about this/these concern(s)? If so, have you been given a diagnosis?
What treatments have you tried?
Females: Are you currently or is there a chance you may be pregnant?
List any accidents, surgeries or hospitalizations you have had (indicate date):
List any allergies or food sensitivities you have.
List all medications you are currently taking, including herbs & supplements & for what reason:

Family Medical History

Please indicate (circle) if you have any family history of the following & list relation to you:

Cancer

Heart Disease

High Blood Pressure

Autoimmune conditions

Diabetes

Thyroid conditions

Osteoporosis

Mental illness

Infertility

Addiction or Substance Abuse

Other:

Lifestyle

Describe a typical breakfast:

Lunch:

Dinner:

Snacks:

What foods do you crave?

Water intake per day:

Daily caffeine intake (what form & how much):

Alcohol consumption (how often & how many drinks):

Recreational drug use? (type and amount):

Do you exercise? If so, describe what you do and how often:

Do you have problems falling asleep?

How many hours of sleep do you typically get per night?

Are you rested in the morning?

Do you wake up in the night? If so, how often & do you have trouble going back to sleep?

How many hours/week do you work?

Do you enjoy your work?

Describe any stressors currently in your life:

Are you satisfied with your energy level?
If not, describe any factors that you know of that contribute to your lack of energy.

On a scale of 1-10, (0= no stress, 10= most stress you've ever experienced) how stressful do you perceive your life to be currently or in the recent past:

Do you have activities/hobbies/downtime in your life that provides a sense of pleasure and fun?

Are you happy in your home environment?

Symptoms & Illnesses- Please indicate (circle) any of the following that you have.

Head/EENT
Dizziness
Headaches
Poor vision
Floaters in eyes
Eye pain or strain
Cataracts
Eye dryness
Excessive tearing
Seasonal allergies
Sensitivities to chemicals/odors
Ear pain/aches
Frequent nosebleeds
Chronic sinus congestion
Swollen or painful sinuses
Frequent sore throats
Mouth or tongue sores
TMJ
Teeth grinding
Dental problems
Other:

Chest/Lungs/Heart
Difficulty breathing
Cough
Asthma/wheezing
Chest/lung congestion
Pneumonia
Bronchitis
Frequent colds
High blood pressure
Low blood pressure
Cardiovascular disease
Chest pain
Heart palpitations
Irregular heartbeats
Blood clots
Stroke
Fainting
Poor circulation
Other:

Digestion/Abdomen
Nausea
Vomiting
Heartburn
Belching/Burping
Indigestion
Bad breath
Diarrhea
Gas
Constipation
Blood in stools
Abdominal pain
Bloating
Rectal pain
Hemorrhoids
Other:

Genito-Urinary

Frequent urination
Urgency to urinate
Painful urination
Cloudy urination
Blood in urine
Incontinence
Kidney stones
Kidney disease
Low sex drive
Men: Erectile dysfunction
STDs
Other:

Emotions

Depression
Anxiety
Panic attacks
Anger easily
Grief
Sadness
Irritability
Fear
Worry
Guilt
Have you ever attempted
or seriously considered suicide?
History of physical or emotional abuse

Skin/Hair/Nails

Dry skin
Dry hair
Hair loss
Rashes
Itching
Hives
Eczema
Psoriasis
Acne
Weak or brittle nails

Musculoskeletal

Neck pain
Shoulder pain
Back pain
Elbow pain
Hand/wrist pain
Hip pain
Knee pain
Muscle pain
Muscle weakness
Muscle cramps
Muscle spasms
Weak or tired back
Weak knees
Other:

Neurological

Seizures
Numbness
Neuropathy/Nerve pain
Tremors
Poor coordination
Loss of balance
Poor memory

Women:

Age of first menses
Pregnancies (how many)
Births (how many)
Miscarriages
Abortions
Length of menstrual cycle:
Number of days you bleed:
Heavy periods
Painful periods
Light periods
Irregular periods
No periods
Clotting with periods
Premenstrual symptoms (list):

Abnormal vaginal discharge
Yeast infections
Breast lumps
Do you practice birth control?
Type of birth control:
Menopause? Age:
Hot flashes

Other/General:

Cancer
HIV
Diabetes
Hepatitis
Edema
Thyroid disorder
Chills (chronic)
Fever (low-grade)
Sweats easily
Nightsweats
Easy bruising
Cold hands
Cold feet
Hot hands
Hot feet
Frequently feels cold
Frequently feels hot
Restlessness