MANY PATHS ACUPUNCTURE AND SHIATSU-ANMA
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Adult Medical History Form

PLEASE COMPLETE ALL **3** PAGES
Your answers on this form will help your provider understand your medical concerns and conditions better. If you are uncomfortable with any question, do not answer it. Best estimates are fine if you cannot remember specific details. **Thank you!**

Name: _____ Phone: _____

Street Address: _____ Date of birth: _____

City, State & Zip: _____Email: _____

How would you rate your general health? ❑ Excellent ❑ Good ❑ Fair ❑ Poor

PRESENT HEALTH CONCERNS:

_____
_____
_____

MEDICATIONS: Prescription and non-prescription medicines, vitamins, supplements, home remedies, birth control pills, herbs:

Medication Dose (eg. mg/pill) How many times per day When started
_____
_____
_____

ALLERGIES or REACTIONS TO MEDICINES:

_____

When were your most recent **IMMUNIZATIONS:**
Hepatitis A ____ Hepatitis B ____ Influenza (Flu Shot) ____ Measles ____ Pneumovax (Pneumonia) ____
Rubella _____ Tetanus (Td) ___ Varicella (chicken pox) shot _____ or Illness ____
When were your most recent **HEALTH MAINTENANCE** screening tests:
Lipid (Cholesterol Screening) ____ Results? _____
Mammogram ____ Results? _____
Ever abnormal? ____ Details: _____
Pap Smear ____ Results?_____
Ever abnormal? ____ Details: _____
HIV _____ Results? _____
Hepatitis C? _____ Results? _____
Liver Panel? _____ Results? _____

PERSONAL MEDICAL HISTORY:

Please indicate whether you have had any of the following medical problems (with dates):

___ Heart disease:
specify type _____
___ High blood pressure
___ High cholesterol
specify type _____
___ Blood transfusion
___ Cancer (Malignancy)
specify type _____

___ Heart attack
___ Diabetes
___ Thyroid problem
___ Bleeding/clotting problem

___Suicide attempt
___ Stroke
___ Alcoholism

Other problems (specify):

SOCIAL HISTORY

Substance & Sexuality

Tobacco Use

Cigarettes ❑ Never ❑ Quit: Date _____
❑ Current: Smoker: packs/day _____ # of yrs _____
Other Tobacco: ❑ Pipe ❑ Cigar ❑ Snuff ❑ Chew
Are you interested in quitting? ❑ No ❑ Yes

Alcohol Use

Do you drink alcohol? ❑ No ❑ Yes: # drinks/week _____
Is alcohol use a concern for you or others? ❑ No ❑ Yes

Drug Use

Do you use any recreational drugs? ❑ No ❑ Yes
Have you ever used needles? ❑ No ❑ Yes
Are you under the influence of intoxicating substances right now? ❑ No ❑ Yes:

Sexual Activity

Sexually Active: ❑ Yes ❑ No ❑ Not currently
Current sex partner(s) is/are: ❑ male ❑ female
Birth control method: _____ ❑ None needed
Have you ever had any sexually transmitted diseases
(STDs)? ❑ No ❑ Yes

Other Concerns

CAFFEINE Intake: ❑ None ❑ Coffee/tea: _____ cups/day
❑ Sodas: _____ /day ❑ Chocolate: _____ oz./day
WEIGHT: Are you satisfied with your weight? ❑ No ❑ Yes
DIET: How do you rate your diet? ❑ Good ❑ Fair ❑ Poor
EXERCISE: Do you exercise regularly? ❑ No ❑ Yes
What kind of exercise? _____
How long (minutes) _____ How often? _____
Have you had acupuncture before? ❑ No ❑ Yes If yes, when and where? _____
Have you had massage/bodywork before? ❑ No ❑ Yes

Socioeconomics Occupation: _____
Employer _____
Years of Education/Highest Degree _____ Marital Status: ❑ S ❑ M ❑ D ❑ W ❑ Other: _____
Spouse/Partner's name: _____ Number of children/ages: _____
Who lives at home with you?
_____

SPECIALTY HISTORY: For women: # pregnancies: ____ # deliveries: ____ # abortions: ____ # miscarriages: ____
1st day, most recent period: _____ Age at 1st period: _____ Frequency of periods: _____
Length of each: _____
Are you currently pregnant? ❑ No ❑ Yes:
Do you have any concerns about your periods? ❑ No ❑ Yes:
_____
Do you have any concerns about menopause? ❑ No ❑ Yes:
_____

REVIEW OF SYMPTOMS: Please check (✓) any <u>current</u> problems you have on the list below:

Constitutional
___ Fevers/chills/sweats
___ Change in energy/weakness
___ Unexplained weight loss/gain
___ Excessive thirst or urination

Eyes
___ Change in vision

Ears/Nose/Throat/Mouth
___ Difficult hearing/ringing in ears
___ Problems with teeth/gums
___ Hay fever/allergies

Chest (breast)
___ Breast lump/nipple discharge

Gastrointestinal
___ Abdominal pain
___ Blood in bowel movement
___ Nausea/vomiting/diarrhea

Genitourinary
___ Nighttime urination
___ Leaking urine
___ Unusual vaginal bleeding
___ Discharge: penis or vagina

Skin
___ Rash/mole change

Neurological
___ Headaches
___ Dizziness/light-headedness
___ Numbness
___ Memory loss
___ Loss of coordination

Sexual, reproductive
___ Problems with sexual function

____Other, explain

Psychiatric
___ Anxiety/stress
___ Problems with sleep
___ Depression

Cardiovascular
___ Chest pain/discomfort
___ Palpitations

Respiratory
___ Cough/wheeze
___ Difficulty breathing

Blood/Lymphatic
___ Unexplained lumps
___ Easy bruising/bleeding

Musculo-skeletal
___ Muscle/joint pain
Describe the quality of the pain as best you can. Is it Constant? Intermittent Sharp? Burning? Dull? ...etc. Mark the location of the pain on the diagrams, and indicate the quality of pain at the location.