HEALTH HISTORY AND REGISTRATION

NAME _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

HOME TEL _____ OTHER TEL _____

E-MAIL ADDRESS _____

EMPLOYER _____

OCCUPATION _____

PHYSICIAN _____ PHYSICIAN'S TEL _____

EMPLOYER _____

HOW DID YOU HEAR ABOUT OUR CLINIC? _____

_____

TODAY'S DATE _____

○ MALE ○ FEMALE | AGE _____

DATE AND TIME OF BIRTH _____

CITY AND STATE OF BIRTH _____

CURRENT HEIGHT _____ WEIGHT _____

STATUS: ○ SINGLE ○ MARRIED ○ SEPARATED
○ DIVORCED ○ WIDOWED ○ LIVING W/ PARTNER
○ OTHER _____

Have you been treated with acupuncture or other oriental medicine before? ○ Yes ○ No

When? _____ Where? _____

HEALTH HISTORY

Circle the 🧍 if you have/had the condition and note the year it started.

Circle the 👪 if there is a family history of the condition.

	YOU	YEAR	FAMILY
Cancer	🧍		👪
Type(s):			
Diabetes	🧍		👪
Hepatitis	🧍		👪
High Blood Pressure	🧍		👪
Heart Disease	🧍		👪
Stroke	🧍		👪
Seizure Disorder	🧍		👪
Thyroid Disease	🧍		👪
Asthma	🧍		👪
Pacemaker	🧍		👪

	YOU	YEAR	FAMILY
Osteoporosis	🧍		👪
Herpes	🧍		👪
AIDS/HIV	🧍		👪
Other STD	🧍		👪
Rheumatic Fever	🧍		👪
Alcoholism	🧍		👪
Allergies	🧍		👪
Type(s):	🧍		👪
Mental Illness	🧍		👪
Kidney Disease	🧍		👪
Anemia	🧍		👪

HABITS

	AMOUNT / WEEK	IF QUIT, YEAR?
Coffee/Tea		
Soda		
Tobacco		
Alcohol		
Drugs		

EXERCISE

Do you exercise regularly? ○ Yes ○ No

If so, how and how often?

_____

_____

_____

DIET

Do you have a special diet now or in the past? (*vegetarian, vegan, raw, Atkins, etc.*) ○ Yes ○ No

Please describe: _____

MEDICATIONS AND SUPPLEMENTS

Please note any medications, herbs, or supplements you take regularly: _____

_____

INJURIES AND SURGERIES

Please note what happened to what body area and when it occurred (*incl. dental*): _____

_____

MAIN COMPLAINTS

Please write in your top three health complaints/ concerns in order of importance to you. Circle the items that make it better or worse and mark on the scale from 1–10 the severity of the condition.

1 _____

When did this start? _____ ago.

Heat makes it: ○ BETTER ○ NO CHANGE ○ WORSE
Cold makes it: ○ BETTER ○ NO CHANGE ○ WORSE
Damp weather: ○ BETTER ○ NO CHANGE ○ WORSE
Exercise/activity: ○ BETTER ○ NO CHANGE ○ WORSE

1 (NO SYMPTOMS) (WORST EVER) 10

2 _____

When did this start? _____ ago.

Heat makes it: ○ BETTER ○ NO CHANGE ○ WORSE
Cold makes it: ○ BETTER ○ NO CHANGE ○ WORSE
Damp weather: ○ BETTER ○ NO CHANGE ○ WORSE
Exercise/activity: ○ BETTER ○ NO CHANGE ○ WORSE

1 (NO SYMPTOMS) (WORST EVER) 10

3 _____

When did this start? _____ ago.

Heat makes it: ○ BETTER ○ NO CHANGE ○ WORSE
Cold makes it: ○ BETTER ○ NO CHANGE ○ WORSE
Damp weather: ○ BETTER ○ NO CHANGE ○ WORSE
Exercise/activity: ○ BETTER ○ NO CHANGE ○ WORSE

1 (NO SYMPTOMS) (WORST EVER) 10