Resolution Health Collaborative, Inc.

Acupuncture Health History Form

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.

_____ _____ _____ _____
First Middle Last Patient ID#

_____ /_____ /_____ Gender: Male Female Other Marital Status: S M D W
Date of Birth

1. When and where did you last receive health care?_____

For what reason? _____

2. Has your case been referred to an attorney? Yes No

3. Please identify the health concerns that have brought you in today in order of importance below:

CONDITION	PAST TREATMENT
A. _____	_____

How does this condition affect you? _____

_____

B. _____	_____

How does this condition affect you? _____

_____

C. _____	_____

How does this condition affect you? _____

_____

D. _____	_____

How does this condition affect you? _____

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

_____

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

6. Do you have any reason to believe you may be pregnant? Yes No

If so, how far along are you? _____

7. Do you have any infectious diseases? Yes No If yes, please identify: _____

8. Family History	Father	Mother	Brothers	Sisters	Spouse	Children
Check those applicable:						
Age (if living)						
Health: G=Good, P=Poor						
Cancer						
Diabetes						
Heart Disease						
High Blood Pressure						
Stroke						
Mental Illness						
Asthma/Hay Fever/Hives						
Kidney Disease						
Age (at death)						
Cause of Death						

Height: _____ Weight: Current _____ Past Max. _____ When?_____

10. Blood Pressure: What is your most recent blood pressure reading? _____/_____

When was this reading taken? _____

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

Scarlet Fever Diphtheria Rheumatic Fever Mumps Measles German Measles Chicken Pox

12. Immunizations (please circle any that you have had):

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

Others: _____

13. Hospitalizations and Surgeries:

Reason	When

14. X-Rays/CAT Scans/MRI's/NMR's/Special Studies:

Reason	When

Please circle any symptoms below that you experience now and underline any that you have experienced in the past.

15. Emotional

Mood Swings	Nervousness	Mental Tension

16. Energy and Immunity

Fatigue	Slow Wound Healing	Chronic Infections	Chronic Fatigue Syndrome

17. Head, Eye, Ear, Nose, and Throat

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

18. Respiratory

Pneumonia	Frequent Common Colds	Difficulty Breathing	Emphysema	Persistent Cough
Pleurisy	Asthma	Tuberculosis	Shortness of Breath	

Other Respiratory Problems: _____

19. Cardiovascular

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

20. Gastrointestinal

Ulcers	Changes in Appetite	Nausea/Vomiting	Epigastric Pain	Passing Gas
Heartburn	Belching	Gall Bladder Disease	Liver Disease	Hepatitis B or C
Hemorrhoids	Abdominal Pain			

Please circle any symptoms below that you experience now and underline any that you have experienced in the past.

21. Genito-Urinary Tract

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

22. Female Reproductive/Breasts

Irregular Cycles	Breast Lumps/ Tenderness	Nipple Discharge	Heavy Flow	Vaginal Discharge
Premenstrual Problems	Clotting	Bleeding Between Cycles	Menopausal Symptoms	Difficulty Conceiving
Painful Periods				

23. Menstrual/Birthing History

Age of First Menses: _____ Birth Control Type: _____ # Abortions: _____

Days of Menses: _____ # Pregnancies: _____ # Live Births: _____

Length of Cycle: _____ # Miscarriages: _____

Please circle any symptoms below that you experience now and underline any that you have experienced in the past.

24. Male Reproductive

Sexual Difficulties	Prostate Problems	Testicular Pain/Swelling	Penile Discharge

25. Musculoskeletal

Neck/Shoulder Pain	Muscle Spasms/ Cramps	Arm Pain	Upper Back Pain	Mid-back Pain
Low Back Pain	Leg Pain	Joint Pain (if so, where?) _____		

26. Neurologic

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

27. Endocrine

Hypothyroid | Hypoglycemia | Hyperthyroid | Diabetes Mellitus | Night Sweats

Feeling Hot or Cold

28. Other

Anemia | Cancer | Rashes | Eczema/Hives | Cold Hands/Feet

Is there anything else we should know? _____

_____

29. Lifestyle

a. Do you typically eat at least three meals per day? Yes No If no, how many? _____

b. Exercise routine: _____

c. Spiritual practice: _____

d. How many hours per night do you sleep? _____ Do you wake rested? Yes No

e. Level of education completed: High School Bachelors Masters Doctorate Other

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

Do you enjoy work? Yes No Why/Why not?_____

g. Nicotine/Alcohol/Caffeine use: _____

h. Have you experienced any major traumas? Yes No Explain: _____

_____

i. How many glasses of non-caffeinated, non-carbonated beverages do you drink per day? _____

j. Television habits: _____ Reading habits: _____

k. Interests and hobbies: _____