CASCO BAY ACUPUNCTURE & MASSAGE
Acupuncture Health History

Name____ **Date**___________
Address____
Phone____________________________ **Email**___________________________
Emergency Contact (name and phone)____________________________________
Date of Birth_______________ **Age**_____ **Gender**: M / F
Marital Status: Single Married Divorced Widowed
How did you hear about me?____
Are you familiar with the concepts of acupuncture or would you like a brief description about acupuncture theory and how it works?_________________

____

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

____

For what reason?

____

2. Please list your health concerns in order of their importance.

<u>Condition</u> <u>Past Treatment</u>

a. _________________ _______________________________________
How does this condition effect you? _______________________________________
b. _________________ _______________________________________
How does this condition effect you? ______________________________________
c. _________________ _______________________________________
How does this condition effect you?_______________________________________
d. _________________ _______________________________________
How does this condition effect you? _______________________________________

3. If applicable, please list any foods, drugs or medications you are hypersensitive to (please include type of reaction):________________________

____

____

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

____

____

5. Do you have any reason to believe you may be pregnant? Yes / No
6. Do you have any infectious diseases? Yes / No If yes, please identify:

____

7. Height: _______Weight: Currently:________ Past Maximum_______ When?____
8. What was your most recent blood pressure reading? ____/____When? _____
9. Please list any significant childhood illnesses:__________________________

____

10. Hospitalizations/Surgeries:

Reason	When	Reason	When
____________________	______	________________________	______
____________________	______	________________________	______
____________________	______	________________________	______
____________________	______	________________________	______

11. X-rays/CAT Scans/MRI'S/Special Studies:

Reason	When	Reason	When
____________________	______	____________________	______
____________________	______	____________________	______

12. Emotional

-Mood Swings -Nervousness -Mental Tension -Anxiety -Depression

13. Energy and Immunity

-Fatigue -Slow Wound Healing -Chronic Infections
-Chronic Fatigue Syndrome

14. 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 -Hay Fever
-Teeth Grinding -TMJ/Jaw Problems -Frequent Sore Throats

15. Respiratory

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

16. Cardiovascular

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

17. 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

18. Genito-Urinary Tract

-Kidney Disease -Painful Urination -Frequent UTI
-Frequent Urination -Heavy Flow -Kidney Stones
-Impaired Urination -Frequent Urination at Night

19. Female Reproductive/Breasts

-Irregular Cycles -Breast Lumps -Nipple Discharge -Heavy Flow
-Vaginal Discharge -Premenstrual Problems -Clotting
-Bleeding Between Cycles -Menopausal Symptoms -Difficulty Conceiving
-Painful Periods -Poor Libido -Sexually Transmitted Disease

20. Menstrual/Birthing History

Age of First Menses____# of Days of Menses____Length of Cycle____

Birth Control Type_________ #of Pregnancies____ # of Miscarriages____
# of Abortions__________ # of Live Births__________

21. Male Reproductive

–Sexual Difficulties –Prostate Problems –Testicular –Pain/Swelling
–Penile Discharge –Poor Libido –Sexually Transmitted Disease

22. Musculoskeletal

–Neck/Shoulder Pain –Muscle Spasms/Cramps –Arm Pain
–Upper Back Pain –Mid Back Pain –Lower Back Pain
–Leg Pain –Joint Pain (if so, where?)____________

23. Neurologic

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

24. Endocrine

–Hypothyroid –Hypoglycemia –Hyperthyroid
–Diabetes Mellitus –Night Sweats –Feeling Hot or Cold

25. Other

–Anemia –Cancer –Rashes –Eczema/Hives
–Cold Hands and Feet

Is there anything else not listed that I should know?_____________________

____

26. Lifestyle:

Do you typically eat three meals per day? Yes / No If not, how many?

____

Exercise Routine: ____
Spiritual Practice:____
How many hours per night do you sleep_______Do you wake rested? Yes / No
Occupation:______________ Employer:__________________ Hours per week:_______
Do you enjoy your work?__________________________Why/Why not?_____________

____

Nicotine/Alcohol Use:____
Have you experienced any major physical or emotional traumas? Yes / No
If so, please explain:____
How many glasses of water do you drink per day?_____________________________

I have provided complete and accurate health information to best of my knowledge and will provide notice of health changes at successive appointments as appropriate.

______________________________ __________
(patient or guardian signature) (date)

____
(please print name)