APPALACHIAN ACUPUNCTURE
Acupuncture. Herbs. Peace of Mind.
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HEALTH HISTORY INTAKE FORM - Confidential Information

Name: Date:

Address:

Preferred Contact Phone #: Home / Mobile / Work

Secondary Phone #: Home / Mobile / Work

Email:

Emergency Contact Name:

Emergency Contact Phone: Home / Mobile / Work

Height Weight Age Date of Birth

Occupation

What brings you here today? What other Treatments have you tried?

Please list approximate dates and briefly describe any hospitalizations, surgeries, or major illnesses you have had:

Please list approximate dates and briefly describe any significant life experiences (accidents, divorce, death in family, physical or emotional trauma):

Please list known allergens and your reaction to them:

Please answer the following:

Yes / No I have high blood pressure
Yes / No I have a pacemaker
Yes / No I am currently being treated with blood thinners / anti-clotting medication
Yes / No I am prone to excessive bleeding and/or poor wound healing
Yes / No I have a medical condition which may cause my heart, liver, spleen or lungs to be enlarged
Yes / No I have surgical implants (please describe) _____
Yes / No I am currently pregnant or trying to become pregnant

Current Medications, Vitamins, Supplements (please use back of page to continue, if necessary):

Name	Dosage	Months/ Years	Reason

Personal Health History (please check all that apply):

[ ] AIDS/ HIV	[ ] Epilepsy / Seizures	[ ] Joint Replacement	[ ] Polio
[ ] Arthritis	[ ] Fibromyalgia	[ ] Kidney Disease	[ ] Rheumatic Fever
[ ] Asthma	[ ] Food Allergies	[ ] Lung Disease	[ ] Seasonal Allergies
[ ] Cancer	[ ] Gout	[ ] Liver Disease	[ ] Stroke
[ ] Diabetes	[ ] Heart/ Artery Disease	[ ] Lyme's Disease	[ ] Tuberculosis
[ ] Drug Use / Alcoholism	[ ] Hepatitis A / B / C	[ ] Mononucleosis/ EBV	[ ] Thyroid Disorder
[ ] Endocrine Disorder	[ ] Herpes Virus	[ ] Multiple Sclerosis	[ ] Other:

Family Heath History (check all that apply to your mother, father, siblings and children):

[ ] Alzheimer's	[ ] Depression	[ ] Liver Disease	[ ] Stroke
[ ] Arthritis	[ ] Diabetes	[ ] Mental Illness	[ ] Thyroid Disorder
[ ] Autoimmune Disease	[ ] Drug Use/ Alcoholism	[ ] Multiple Sclerosis	[ ] Other:
[ ] Cancer	[ ] Heart Disease	[ ] Parkinson's Disease	
[ ] Cholesterol, Elevated	[ ] Kidney Disease	[ ] Seizures/ Tremors	

Diet / Lifestyle

Your Diet:	[ ] Low-Carb	[ ] High-Protein	[ ] Vegetarian
	[ ] Low-Fat	[ ] Gluten Free	[ ] Vegan

Any dietary restrictions? Please describe: _____

Alcohol ____	drinks per week	Tobacco Products ____	packs per day / week
Coffee / Tea ____	cups per day	Sleep (on average) ____	hours per night
Soda ____	drinks per day	Exercise ____	times per week
Fast/ Convenience Food ____	meals per week	TV/ Computer/ Gaming ____	hours per day
Water ____	ounces per day	Work ____	hours per week

How many bowel movements do you have? _____ Per day/ week Any blood or mucus in stool? Yes/ No

Are they: [ ] Well-formed [ ] Loose [ ] Small Pebbles [ ] Tan [ ] Almost Black [ ] Difficult to pass [ ] Sticky

How is your energy level? High/Average/Low How would you rate your stress level? High/Average/Low

What are your primary sources of stress? _____

How do you manage stress/ care for yourself? _____

Please indicate any symptoms that you currently experience or have experienced in the last year:

General
__Poor appetite
__Heavy appetite
__Excessive thirst
__Aversion to cold
__Aversion to heat
__Recent weight change
__Poor sleep
__Heavy sleep
__Dream-disturbed sleep
__Fatigue
__Weakness
__Cold hands & feet
__Poor circulation
__Excessive sweating
__Night sweats
__Chills
__Fever/ heat sensations
__Frequent colds
__Easy bruising
__Alcohol #/week:_____
__Tobacco #/day:_____
__Occupational hazards

Emotions
__Poor memory
__Difficulty concentrating
__Depression
__Anxiety
__Irritability
__Easily stressed

Ears & Eyes
__Ringing
__Hearing loss
__Frequent Ear Infections
__Earache
__Glasses/ contacts
__Blurred vision
__Poor night vision
__Spots or floaters
__Eye inflammation
__Dry eyes
__Glaucoma
__Cataracts

Head & Neck
__Headaches/ Migraines
__Stiff neck
__Dizziness
__Fainting

Nose, Throat & Mouth
__Sinus issues
__Hay fever/ allergies
__Frequent sore throat
__Swollen glands
__Difficulty swallowing
__Mouth / tongue ulcers
__Nosebleed
__Dry nose
__Dry mouth
__Dry throat
__Nasal congestion
__Loss of voice
__Excessive phlegm
__Clenching jaw
__Grinding teeth
__Prone to cavities
__TMJ
__Facial pain
__Gum disease

Skin & Hair
__Hives/ rashes/ eczema
__Dry skin
__Skin texture changes
__Mole/ lump changes
__Itching
__Dry hair
__Hair loss
__Change in hair color
__Hair texture changes

Musculoskeletal
__Joint pain/disorder
__Reduced joint motion
__Sore muscles
__Weak muscles
__Difficulty walking
__Neck/shoulder pain
__Upper back pain
__Lower back pain
__Rib pain

Respiratory
__Shortness of breath
__Tight chest
__Asthma / wheezing
__Chronic cough: wet/dry
__Coughing up phlegm
__Coughing up blood
__Pneumonia

Cardiovascular
__High blood pressure
__Low blood pressure
__Chest pain / tightness
__Palpitations
__Rapid heart beat
__Irregular heart beat
__Poor circulation
__Swollen ankles
__Phlebitis
__Anemia

Gastrointestinal
__Nausea
__Indigestion
__Hiccups
__Acid reflux
__Bloating
__Stomach pain
__Gas
__Bad breath
__Vomiting
__Intestinal cramping
__Diarrhea
__Constipation
__Bloody or black stool
__Mucus in stool
__Hemorrhoids
__Gall Bladder disorder

Neurological
__Seizures
__Tremors
__Numbness or tingling
__Restless leg
__Pain
__Paralysis
__Poor coordination
__Dizziness

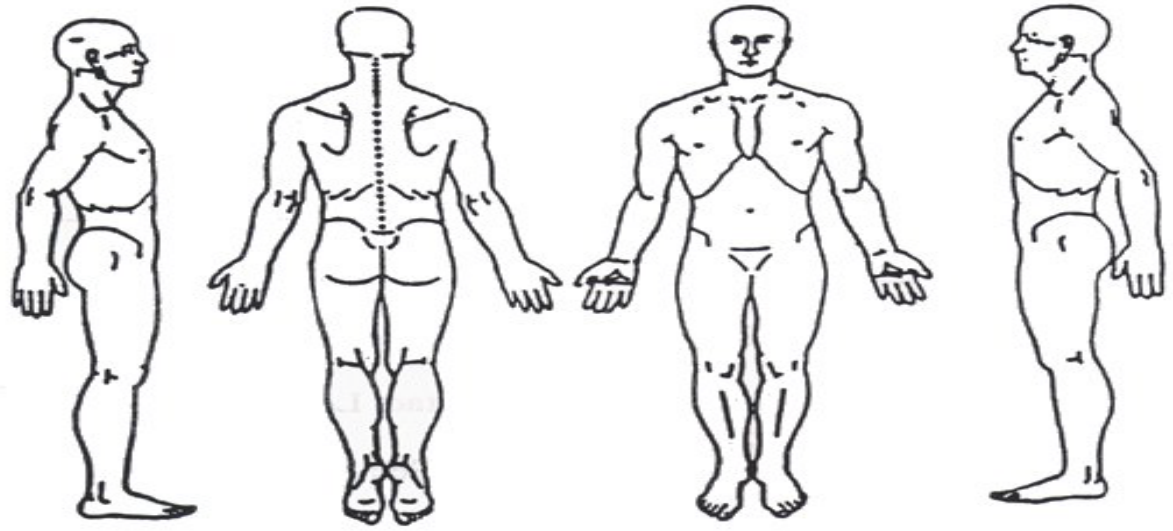
Urinary
__Painful urination
__Frequent urination
__Urgent urination
__Incomplete urination
__Decreased urine flow
__Blood in urine
__Unable to hold urine
__Wake to urinate
__Kidney stones
__Lower abdominal pain

Male Reproductive
__Increased libido
__Decreased libido
__Impotence
__Pain of genitalia
__Genital itching
__Testicular pain
__Testicular swelling
__Lumps in testicle(s)

Gynecological
Date of last period _____
Is it possible that you are pregnant? _____
Are you currently trying to become pregnant?_____
Age menses began _____
Age at menopause_____
Cycle length _____
Duration of flow _____
Pregnancies_____
Live births_____
Date of last PAP _____
__Irregular periods
__Painful periods
__Heavy bleeding
__Menstrual clots
__PMS symptoms
__Bleeding b/w cycles
__Vaginal discharge
__Vaginal odor
__Vaginal sores
__Vaginal dryness
__Vaginal itching
__Vaginal pain
__Painful intercourse
__Breast lumps
__Breast tenderness
__Abnormal PAP
__Abnormal mammogram
__Hormone Replacement
__Birth control
__IUD or Hormone IUD
__Ectopic pregnancy
__Endometriosis
__Uterine fibroids
__Mastectomy
__Hysterectomy
__Decreased libido
__Increased libido
__Bone density changes

Pain

Please indicate areas of concern (pain, tension, numbness, tingling, swelling, etc.):



How long have you had this pain?

Describe the onset of your pain:

On a scale of 1-10 (10 being worst), how strong is your pain?

What does your pain feel like? (Check all that apply)

[ ] Dull	[ ] Sore	[ ] Electrical	[ ] Comes and goes	[ ] Other:
[ ] Sharp	[ ] Achy	[ ] Burning	[ ] Fixed	_____
[ ] Stabbing	[ ] Cramping	[ ] Constant	[ ] Moves around	

Does the pain radiate? Yes / No If yes, where? _____

What helps the pain?

[ ] Ice	[ ] Rest	[ ] Pressure	[ ] Massage	[ ] Other:
[ ] Heat	[ ] Movement	[ ] Moisture	[ ] Nothing	_____

What aggravates the pain?

[ ] Ice	[ ] Rest	[ ] Pressure	[ ] Massage	[ ] Other:
[ ] Heat	[ ] Movement	[ ] Moisture	[ ] Nothing	_____

What other treatments have you tried for this pain?

Is there anything else that you would like us to know?

Thank you for taking the time to complete this form. We look forward to working with you!