



APPALACHIAN ACUPUNCTURE
 113 E. Unaka Ave, Johnson City, TN 37601
 423.928.9394 • www.AppalachianAcupuncture.com

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):

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

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

- | | | | |
|--|---|--|---|
| <input type="checkbox"/> Alzheimer's | <input type="checkbox"/> Depression | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Mental Illness | <input type="checkbox"/> Thyroid Disorder |
| <input type="checkbox"/> Autoimmune Disease | <input type="checkbox"/> Drug Use/ Alcoholism | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Other: |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Parkinson's Disease | |
| <input type="checkbox"/> Cholesterol, Elevated | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Seizures/ Tremors | |

Diet / Lifestyle

- | | | | |
|------------|-----------------------------------|---------------------------------------|-------------------------------------|
| Your Diet: | <input type="checkbox"/> Low-Carb | <input type="checkbox"/> High-Protein | <input type="checkbox"/> Vegetarian |
| | <input type="checkbox"/> Low-Fat | <input type="checkbox"/> Gluten Free | <input type="checkbox"/> 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

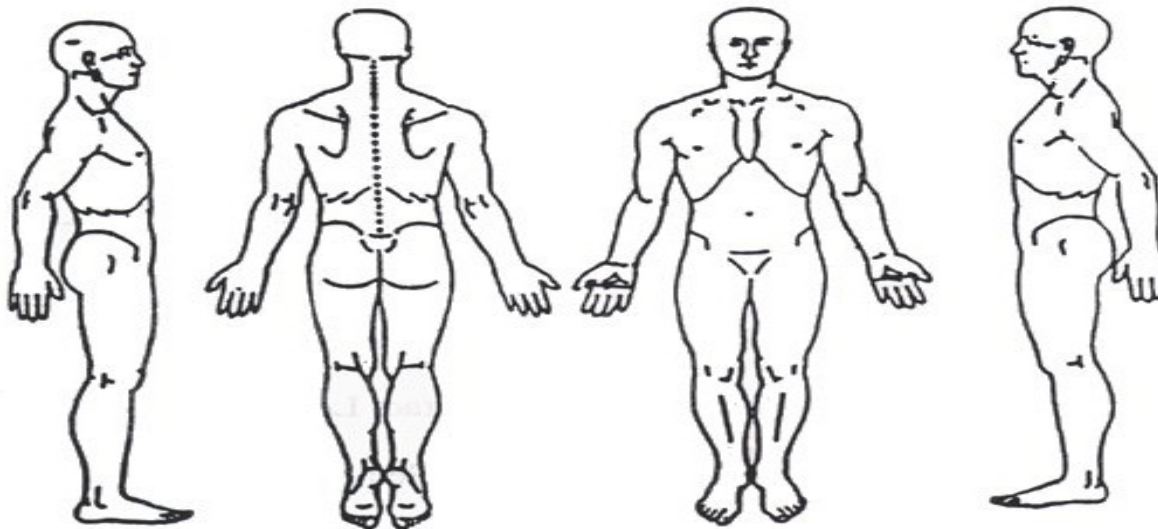
- Increased libido
- Decreased libido
- Impotence
- Pain of genitalia
- Genital itching
- Testicular pain
- Testicular swelling
- Lumps in testicle(s)

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)

- | | | | | |
|-----------------------------------|-----------------------------------|-------------------------------------|---|---------------------------------------|
| <input type="checkbox"/> Dull | <input type="checkbox"/> Sore | <input type="checkbox"/> Electrical | <input type="checkbox"/> Comes and goes | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Sharp | <input type="checkbox"/> Achy | <input type="checkbox"/> Burning | <input type="checkbox"/> Fixed | |
| <input type="checkbox"/> Stabbing | <input type="checkbox"/> Cramping | <input type="checkbox"/> Constant | <input type="checkbox"/> Moves around | |

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

What helps the pain?

- | | | | | |
|-------------------------------|-----------------------------------|-----------------------------------|----------------------------------|---------------------------------------|
| <input type="checkbox"/> Ice | <input type="checkbox"/> Rest | <input type="checkbox"/> Pressure | <input type="checkbox"/> Massage | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Heat | <input type="checkbox"/> Movement | <input type="checkbox"/> Moisture | <input type="checkbox"/> Nothing | |

What aggravates the pain?

- | | | | | |
|-------------------------------|-----------------------------------|-----------------------------------|----------------------------------|---------------------------------------|
| <input type="checkbox"/> Ice | <input type="checkbox"/> Rest | <input type="checkbox"/> Pressure | <input type="checkbox"/> Massage | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Heat | <input type="checkbox"/> Movement | <input type="checkbox"/> Moisture | <input type="checkbox"/> 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!