

# HEALTH HISTORY for ACUPUNCTURE

Name \_\_\_\_\_ Today's Date (M/D/Y) \_\_\_\_\_

Birth Date (M/D/Y) \_\_\_\_\_ Age: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

City: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Cell number: \_\_\_\_\_

Email Address: \_\_\_\_\_

Emergency Contact and their phone number: \_\_\_\_\_

Any recent emergency visits to the hospital? \_\_\_\_\_ What for? \_\_\_\_\_

Have you had acupuncture before? \_\_\_\_\_ What for? \_\_\_\_\_

Who referred you? \_\_\_\_\_

What brought you here today? \_\_\_\_\_

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## **Please list the Medications you're currently taking:**

Med _____	Dose _____	Since when? _____
Med _____	Dose _____	Since when? _____
Med _____	Dose _____	Since when? _____
Med _____	Dose _____	Since when? _____
Med _____	Dose _____	Since when? _____
Med _____	Dose _____	Since when? _____

## **Please list all the Supplements/Vitamins you're currently taking:**

Name _____	Since when? _____
Name _____	Since when? _____
Name _____	Since when? _____
Name _____	Since when? _____
Name _____	Since when? _____
Name _____	Since when? _____

***Missed appointment fee (without 24 hours notice): \$35 for the first missed appointment and the full appointment fee will be charged for all subsequent missed appointments.***

***Initials*** \_\_\_\_\_

**Please list in order of importance each of your health ailments and injuries that you would like help with today, list one item per box (up to 3):**

1. \_\_\_\_\_  
 When did this start? \_\_\_\_\_

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  
 Other therapies / remedies your currently using for this: \_\_\_\_\_

2. \_\_\_\_\_  
 When did this start? \_\_\_\_\_

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  
 Other therapies / remedies your currently using for this: \_\_\_\_\_

3. \_\_\_\_\_  
 When did this start? \_\_\_\_\_

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  
 Other therapies / remedies your currently using for this: \_\_\_\_\_

**Health History**

Please mark any health conditions you or your immediate family has experienced by writing **P** if you had it in the past, write **C** if you currently have it, and write **F** if anyone in your immediate family has it:

- Allergies (please list) \_\_\_\_\_
- Anemic
- Arthritis (type) \_\_\_\_\_
- Asthma
- Blood Clotting Disorder
- Blood Transfusion
- Cancer
- COPD
- Dementia
- Diabetes (list type) \_\_\_\_\_

- Heart Disease
- High / Low Blood Pressure
- High Cholesterol
- HIV / Aids
- Irritable Bowel or Ulcerative Colitis
- Kidney Stones
- Lupus or Sjogren's syndrome
- Meningitis
- Migraines
- Mental Health Diagnosis

<input type="checkbox"/> Depression <input type="checkbox"/> Emphysema <input type="checkbox"/> Epilepsy <input type="checkbox"/> Fibromyalgia <input type="checkbox"/> Gender Transition <input type="checkbox"/> Goiter <input type="checkbox"/> Gout <input type="checkbox"/> Head concussions <input type="checkbox"/> Herpes (list type) _____ <input type="checkbox"/> Hepatitis (list type) _____ <input type="checkbox"/> Heart Attack <input type="checkbox"/> Other diagnosis not listed: _____	<input type="checkbox"/> Multiple Sclerosis <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Pacemaker or Defibrillator <input type="checkbox"/> Parkinson Disease <input type="checkbox"/> Polio <input type="checkbox"/> Rheumatic Fever <input type="checkbox"/> Scarlet Fever <input type="checkbox"/> Skin condition (type) _____ <input type="checkbox"/> Stroke <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Thyroid Disease <input type="checkbox"/> Other health ailment: _____
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List your Injuries & Surgeries: _____ _____ _____ _____ _____ _____	Physician's Name and phone number : _____ _____ Date of Last Physical: _____ Other concurrent therapies i.e. naturopath, chiropractic etc. _____ _____ _____
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Do you have any implants, pins, staples or artificial joints? If so, when and where \_\_\_\_\_

Have you had any botox injections or skin filler injections? If so, when and where \_\_\_\_\_

Habits: Please list amount per day and if quit what year?

Coffee / Tea \_\_\_\_\_

Soda \_\_\_\_\_

Smoking \_\_\_\_\_

Recreational Drugs \_\_\_\_\_

Chew Snuff (tobacco) \_\_\_\_\_

Exercise:

Do you exercise regularly? \_\_\_\_\_

What do you do and how often? \_\_\_\_\_

Water:

How much water do you drink daily? \_\_\_\_\_

Stress Level: Low 1 2 3 4 5 6 7 8 9 10 High

How is your energy level? Very Low 1 2 3 4 5 6 7 8 9 10 Very High

How is your body temperature? Very Cold 1 2 3 4 5 6 7 8 9 10 Very Hot

Please answer by checking box  if you are experiencing the following on a regular basis:

<p><b>Sleep:</b>          Do you sleep well at night? _____          How many hours do you sleep? _____          What time do you go to bed? _____  <input type="checkbox"/> trouble falling asleep  <input type="checkbox"/> wake frequently? What time? _____  <input type="checkbox"/> if waking, how long does it take to fall back to asleep again? _____  <input type="checkbox"/> wake to urinate? _____ How many times each night? _____  <input type="checkbox"/> wake feeling rested  <input type="checkbox"/> restless or cramping legs  <input type="checkbox"/> nightmares  <input type="checkbox"/> night sweats  <input type="checkbox"/> snoring  <input type="checkbox"/> other: _____</p>	<p><b>Bowel Movements:</b>          How many bowel movements do you have each week? _____ Laxative use? _____          Are your stools:  <input type="checkbox"/> well formed  <input type="checkbox"/> hard or dry  <input type="checkbox"/> pellet like  <input type="checkbox"/> black stool  <input type="checkbox"/> alternating loose and hard  <input type="checkbox"/> undigested food in stool  <input type="checkbox"/> early morning diarrhea  <input type="checkbox"/> feels unfinished  <input type="checkbox"/> long and thin stools  <input type="checkbox"/> blood or mucus on stool  <input type="checkbox"/> hemorrhoids or anal fissures  <input type="checkbox"/> painful bowel movements  <input type="checkbox"/> other _____</p>
<p><b>Bladder:</b>  <input type="checkbox"/> clear urine  <input type="checkbox"/> cloudy urine  <input type="checkbox"/> yellow / light yellow  <input type="checkbox"/> painful  <input type="checkbox"/> dark yellow  <input type="checkbox"/> frequent urination  <input type="checkbox"/> urgent urination  <input type="checkbox"/> leakage with coughing or exercise  <input type="checkbox"/> dribbling urination          Men  <input type="checkbox"/> impotence  <input type="checkbox"/> prostate problems  <input type="checkbox"/> premature ejaculation  <input type="checkbox"/> infertility  <input type="checkbox"/> other: _____</p>	<p><b>Digestion:</b>          How is your digestion? _____          Please list any special dietary habits or food allergies you have: _____          _____  <input type="checkbox"/> poor appetite  <input type="checkbox"/> rapid hunger after eating  <input type="checkbox"/> abdominal bloating  <input type="checkbox"/> stomach or abdominal pain  <input type="checkbox"/> acid reflux or heartburn  <input type="checkbox"/> belching or hiccups  <input type="checkbox"/> hernia  <input type="checkbox"/> bad breath  <input type="checkbox"/> frequent gas  <input type="checkbox"/> ulcers  <input type="checkbox"/> other: _____</p>
<p><b>Unusual Thirst:</b>  <input type="checkbox"/> thirsty (more than normal)  <input type="checkbox"/> thirsty but can't quench thirst  <input type="checkbox"/> thirst but no desire to drink  <input type="checkbox"/> no thirst</p>	<p><b>Unusual sweating:</b>  <input type="checkbox"/> sweat too easily  <input type="checkbox"/> spontaneous sweat without reason  <input type="checkbox"/> don't usually sweat  <input type="checkbox"/> night sweats  <input type="checkbox"/> hotflashes</p>

<p><b>Which emotions do you experience on a daily basis?</b></p> <input type="checkbox"/> joy / peace <input type="checkbox"/> anger <input type="checkbox"/> depression <input type="checkbox"/> sadness or grief <input type="checkbox"/> fear or anxiety <input type="checkbox"/> guilt <input type="checkbox"/> indifference <input type="checkbox"/> excessive thinking <input type="checkbox"/> moodiness <input type="checkbox"/> easily stressed <input type="checkbox"/> worry <input type="checkbox"/> considered or attempted suicide <input type="checkbox"/> seeing a therapist or counselor <input type="checkbox"/> history of mental illness <input type="checkbox"/> other: _____	<p><b>Women:</b></p> <p>How is your menstruation? _____</p> <p>Date of last period? _____</p> <p>Are you pregnant? _____ If so how many weeks? _____</p> <p>How many pregnancies have you had? _____</p> <p>How many live births? _____</p> <p>Age at menopause? _____</p> <input type="checkbox"/> painful periods <input type="checkbox"/> excessive flow <input type="checkbox"/> bleeding between periods <input type="checkbox"/> irregular cycle <input type="checkbox"/> PMS <input type="checkbox"/> uterine fibroids <input type="checkbox"/> endometriosis <input type="checkbox"/> surgeries: _____ <input type="checkbox"/> other: _____
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**Please check box if you experience any of the following symptoms regularly:**

<input type="checkbox"/> headaches, location _____ <input type="checkbox"/> nosebleeds <input type="checkbox"/> frequent colds <input type="checkbox"/> sinus congestion <input type="checkbox"/> aversion to wind or cold <input type="checkbox"/> runny nose <input type="checkbox"/> cough <input type="checkbox"/> poor hearing <input type="checkbox"/> ear aches <input type="checkbox"/> ringing in ears <input type="checkbox"/> blurry vision <input type="checkbox"/> color blindness <input type="checkbox"/> night blindness <input type="checkbox"/> eyes: redness / pain / dry <input type="checkbox"/> floaters or spots in vision <input type="checkbox"/> bursitis <input type="checkbox"/> swollen joints <input type="checkbox"/> carpal tunnel <input type="checkbox"/> childhood illnesses <input type="checkbox"/> bedwetting as a child	<input type="checkbox"/> pain in ribcage <input type="checkbox"/> breast lumps or cysts <input type="checkbox"/> tight chest <input type="checkbox"/> chest pain <input type="checkbox"/> frequent sighing <input type="checkbox"/> lump in throat <input type="checkbox"/> difficulty breathing <input type="checkbox"/> shortness of breath <input type="checkbox"/> heart palpitations <input type="checkbox"/> grinding teeth or TMJ <input type="checkbox"/> mouth sores or cold sores <input type="checkbox"/> gum disease <input type="checkbox"/> copious saliva <input type="checkbox"/> unusual hair loss <input type="checkbox"/> poor circulation <input type="checkbox"/> dizziness or vertigo <input type="checkbox"/> seizures <input type="checkbox"/> lack of strength <input type="checkbox"/> abuse survivor <input type="checkbox"/> hypoglycemia	<input type="checkbox"/> poor memory <input type="checkbox"/> inability to concentrate <input type="checkbox"/> dry skin or hair <input type="checkbox"/> fatigue or tiredness <input type="checkbox"/> low or high libido <input type="checkbox"/> pain that comes and goes <input type="checkbox"/> cold hands and feet <input type="checkbox"/> numbness <input type="checkbox"/> ligament/tendon problems <input type="checkbox"/> bleed or bruise easily <input type="checkbox"/> tremors <input type="checkbox"/> dermatitis <input type="checkbox"/> psoriasis <input type="checkbox"/> fungal infections <input type="checkbox"/> acne <input type="checkbox"/> rosacea <input type="checkbox"/> color blindness <input type="checkbox"/> hives <input type="checkbox"/> skin tags <input type="checkbox"/> other _____
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## CONSENT FORM

I, the undersigned, understand that methods of treatment used in this practice may include, but are not limited to: acupuncture, ear acupuncture, electro-acupuncture, facial rejuvenation acupuncture, cupping massage, Chinese herbal therapy, tuina, guasha, moxibustion, aromatherapy massage, infrared therapy, bodytalk, reiki, sound therapy and nutritional counseling.

I understand that acupuncture, ear acupuncture, moxibustion, guasha and cupping are all safe methods of treatment. Potential risks include temporary bruising, swelling, bleeding, numbness and tingling, and soreness at the needling site that may last a few days. Unusual risks of acupuncture include dizziness, fainting or nerve damage. Organ damage from the needle is another extremely rare risk and I understand my practitioner is trained thoroughly to avoid this risk. Infection is possible, although the clinic uses alcohol and sterile disposable needles and maintains a safe and clean environment. Potential risks of moxibustion health therapy are burns, blistering, or scarring. Temporary bruising or redness lasting a few days is a common side effect of cupping and gua ha. I fully understand that there is no implied or stated guarantee of success or effectiveness of a specific treatment or series of treatments.

I understand that herbal and nutritional supplements recommended to me by my acupuncturist are safe in the recommended doses. Large doses of herbs taken without my practitioner's recommendation may be toxic, and some herbs are inappropriate during pregnancy. Some possible side effects of herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives and tingling of the tongue. I understand that I must stop taking any herbs and notify my acupuncturist as soon as I experience any discomfort or adverse effects.

I understand that all information regarding my health and personal records will be kept confidential.

I do not expect my practitioner to be able to anticipate and explain all possible risks and complications of treatment. I rely on the practitioner to exercise his or her judgment in my best interest during the course of treatment, based upon the facts then known. I will inform my practitioner of any health changes.

**I recognize that scheduling an appointment involves the reservation of a time specifically for me and that consequently, a minimum of 24-hrs notice is required to reschedule or cancel an appointment. Unless otherwise agreed to in advance, a \$35 service fee will be charged for the first missed appointment and the full appointment fee will be charged for all subsequent missed appointments. A deposit may be required for future appointments. Initial \_\_\_\_\_**

Payment is due on day of service. Any dollar amounts not covered by insurance must be paid on day of service.

Initial \_\_\_\_\_

In signing this form, I acknowledge any inherent risks, and give my consent for treatment, payment, and healthcare operations received, incurred or carried out by Janis Krause at Dragonfly Acupuncture and Chinese Medicine Clinic.

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Patient Name & Signature

Date