Asheville Community Acupuncture

Health History Questionnaire and Registration

PATIENT INFORMATION	CONTACT INFORMATION
Date_____ Name_____ Address_____ City State Zip_____ Age_____ Birthdate _____ Occupation _____ Primary physician _____ How did you hear about us?_____	Home phone _____ Work phone _____ Other/cell phone _____ Email _____ Another person we may contact if needed: Name _____ Relationship_____ Home phone _____ Work/cell phone_____

HEALTH HISTORY

What are your health goals / primary concerns that bring you in for treatment?

1 - _____

2 - _____

3 - _____

How is your sleep?

_____

How is your digestion?

_____

List medications or food supplements you are taking:

_____

_____

_____

List serious illnesses, accidents or surgeries:

_____

_____

Check illnesses that have occurred in blood relatives:

□ Diabetes □ High blood pressure □ Stroke
□ Cancer □ Heart disease □ Kidney disease

Have you ever had acupuncture before? Yes / No
Have you ever taken Chinese Herbs? Yes / No

Check symptoms you have or have had in the last year:

□ Depression
□ Difficulty in focusing
□ Dizziness
□ Easily startled
□ Excessive worry
□ Excessive anger
□ Excessive fear
□ Fatigue/tiredness
□ Headaches
□ Loss of sleep/poor sleep
□ Loss or gain of weight
□ Nervousness/irritability
□ Overwhelmed by life

Check conditions you have or have had in the past:

□ AIDS
□ Allergies
□ Anemia
□ Arthritis
□ Bleeding disorders
□ Breast lump
□ Cancer
□ Diabetes

How long has it been since you have had a complete medical exam?

_____

HEALTH HISTORY Continued… Check symptoms you have or have had in the last year:

MUSCLE/JOINT/BONES
□ Tremors
□ Cramps
□ Swollen joints
Pain, weakness, numbness in:
- □ Arms or Hips
- □ Back Legs
- □ Feet
- □ Neck
- □ Hands
- □ Shoulders
- □ Other_____

EYES/EAR/NOSE/THROAT/RESPIRATORY
□ Asthma/wheezing
□ Blurred or failing vision
□ Difficulty breathing
□ Earache
□ Enlarged glands
□ Eye pain
□ Frequent colds
□ Hay fever
□ Hoarseness
□ Gum trouble
□ Nose bleeds
□ Loss of hearing
□ Persistent cough
□ Ringing in ears
□ Sinus problems

SKIN
□ Boils
□ Bruise easily
□ Dry skin
□ Itching/rash
□ Sensitive skin
□ Sore won't heal
□ Sweats

FOR MEN ONLY
□ Erection difficulties
□ Penis discharge
□ Prostate trouble

GENITO/URINARY
□ Blood/pus in urine
□ Frequent urination
□ Inability to control urine
□ Kidney infection/stones
□ Lowered libido

CARDIOVASCULAR
□ Chest pain
□ Hardening of arteries
□ High or low blood pressure
□ Pain over heart
□ Poor circulation
□ Previous heart attack
□ Rapid/irregular heart beat
□ Swelling of ankles

GASTROINTESTINAL
□ Belching, gas or bloating
□ Colon trouble
□ Constipation
□ Diarrhea
□ Difficulty swallowing
□ Distention of abdomen
□ Excessive hunger
□ Gall bladder trouble
□ Hemorrhoids (piles)
□ Indigestion
□ Nausea
□ Pain over stomach
□ Poor appetite
□ Vomiting

FOR WOMEN ONLY
□ Bleeding between periods
□ Clots in menses
□ Excessive menstrual flow
□ Extreme menstrual pain
□ Irregular cycle
□ Menopausal symptoms
□ PMS
□ Previous miscarriage
□ Scanty menstrual flow
Could you be pregnant? _____

SIGNATURE

The information on this form is correct to the best of my knowledge.
Signature_____ Date _____