ASHEVILLE COMMUNITY ACUPUNCTURE

HEALTH HISTORY

Preferred Name: _____ Today's Date: _____ Age:_____

Pronouns (if any):_____ Occupation: _____ Date of Birth: _____

Address: _____

Email: _____ Have you ever had Acupuncture? Y N

Preferred Phone #: _____ Have you ever taken Chinese Herbs? Y N

Emergency Contact Name/Relationship/Phone #: _____

Primary Physician: _____ How did you hear about us? _____

Gender Identity if applicable- Include any details you would like to share about your transition (medical, social, etc.) Do you experience Dysphoria?
Primary Concern that brought you in for treatment:
Secondary Concern:
Please list any Allergies/Sensitivities
Medications, Supplements, Recreational Drugs
List any conditions, illnesses, accidents, and/or surgeries

Please circle any that apply to you

Could you be **PREGNANT? _____** Pacemaker /Biomedical Device Aids HIV Diabetes Breast lump

Arthritis Hepatitis Anemia Bleeding Disorders High/Low Blood Pressure Artificial joints Cancer

Circle illnesses that have occurred in blood relatives

Diabetes High Blood Pressure Heart Disease High Cholesterol Kidney Disease Stroke Cancer

Please mark with a **"C"** for currently experiencing and a **"P"** for experienced in the past

WOOD

___ Sigh frequently
___ Vague discomfort/pain in chest, or ribs
___ Cold hands AND feet that comes & goes
___ Face feels hot/red/flushed when upset
___ Eye Floaters (seeing spots in vision)
___ Irritability/ Easily Angered
___ Liver Disease
___ Depression/ Stress
___ Red, Dry, and/or itchy eyes
___ Clench jaw/Grind teeth
___ Bitter taste in mouth
___ Crave sour foods
___ Gallbladder trouble
___ More than one drink of alcohol most days
___ Seizures

WATER

___ Ringing in ears/difficulty hearing
___ Low back/Leg/Knee Coldness/sore/weakness
___ Frequent Urination
___ Wake more than 2 times at night to urinate
___ Incontinence (Leaking urine at any time)
___ Low Sex Drive
___ Low Sex Desire
___ Constant cold feet/toes
___ Dry throat/mouth/eyes
___ Issues with teeth
___ Night sweats
___ Past or current Trauma
___ Hard to stay asleep
___ Do you crave salty food
___ Swelling of the legs
___ Kidney Disease

EARTH

___ Fatigue (Time of day? _____)
___ Constant cold hands/fingers/nose
___ Dizziness upon standing
___ Weak feeling in arms and/or legs
___ Excess Belching and/or gas
___ Nausea
___ Vomiting
___ Excess Worry
___ Feeling of heaviness in body

EARTH

___ Bad breath
___ Bleeding gums
___ Acid Reflux
___ Easy bruising
___ Carb/sugar/sweet cravings
___ Diminished or lack of appetite
___ Distention/Bloating after eating
___ Prolapse/Hemorrhoids
___ Chronic Yeast infections

FIRE

___Heart palpitations
___Previous Stroke or Heart attack
___Blood Clot
___Varicose/Spider Veins
___Chest tightness or pain
___Easily startled
___Lack of joy in life
___Hardening of arteries or high cholesterol
___Restlessness
___Sores on tongue/mouth
___Rapid/ Irregular heart beat
___Anxiety and/or Panic Attacks
___Do you crave bitter food

BLOOD

___Poor memory, forgetfulness, and/or brain fog
___Poor night vision
___Cramping of muscles esp. calves at night
___General Dizziness
___Twitching muscles
___Pale nails, brittle nails, or ridges/lines on nails
___Dry skin/ Dry hair
___Numbness in limbs
___Difficulty falling asleep
___Muscle Twitches

METAL

___Shortness of breath
___Chronic Cough
___Smoker/Past Smoker
___Asthma
___Frequent colds
___Seasonal Allergies
___Itching/ Rashes
___Spontaneous sweating during the daytime
___Sadness or a lot of crying
___Do you crave spicy food
___Sensitive Skin
___Swollen Face, Hands, or fingers

FLUIDS

___Crave large amounts of liquid (Big gulps)
___Crave small amounts of liquid (Small sips)
___Craves cold water
___Dry mouth with not much thirst
___Dry mouth with a lot of thirst
___Prefers room temp or warm water
___Cloudy Urine
___Painful Urination
___Mucous (from chest, nose, throat)

Bowel Movements

Frequency:

Daily___ Every 2-3 days ___ 1 x a week___

___More than 3 times a day
___Sticky/ Wipe more than 3-4 times
___Incomplete evacuation
___Require deep breathing and push to go
___Loose/Undigested food
___Small and hard like pebbles or little balls
___Alternates Diarrhea and Constipation

MENSES

If you get a menstrual cycle, please answer, or circle the following:

Cycle Length: 20-27 days 28-33 days >33 days

Menses Length: 1-2 days 3-7 days >7 days

Spotting: Pre Menses Post Menses Mid Cycle Other

Flow: Light Moderate Heavy Varies

Color: Dark Red Bright Red Brown Pale Red Pink Black Purple-Red

Quality: Thin Thick Small clots Big clots Stringy Moderate

Cramping: Pre Menses Menses Post Menses Low back Abdomen Mid Cycle

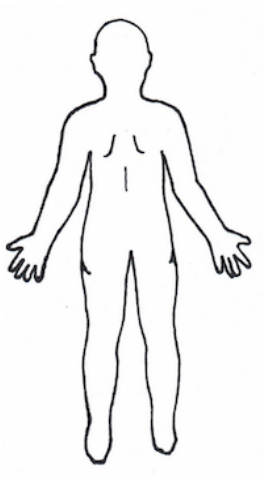
If you lost your menses, when did that happen? _____

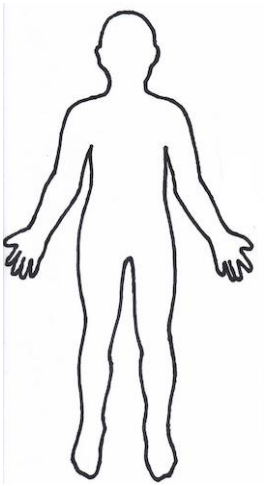
Menopause Age and Year: _____ Number of Pregnancies: _____ Number of Births: _____

On the diagram below, please show where you are experiencing pain using the following letters:

A: Achy **B:** Burning **C:** Cramping **D:** Dull **R:** Throbbing **N:** Numbness **T:** Tingling **S:** Sharp/StabbingFRONT

Back





Front

L **R** **R** **L**

Is there anything else you would like us to know?

Patient Name: _____ Signature of Patient: _____ Date: _____

Parent/Guardian Signature: _____