Sarana community acupuncture

Health History Form

970 San Pablo Avenue
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Name: _____ Date: _____/_____/_____
(first) (middle) (last)

Are you new to acupuncture?: **YES NO** Date of Birth:_____/_____/_____ Age:_____ Gender / Pronoun:_____ Occupation:_____

Emergency Contact (optional): Name_____ Phone #:_____

PLEASE LIST THE CONDITIONS YOU WISH TO HAVE TREATED:

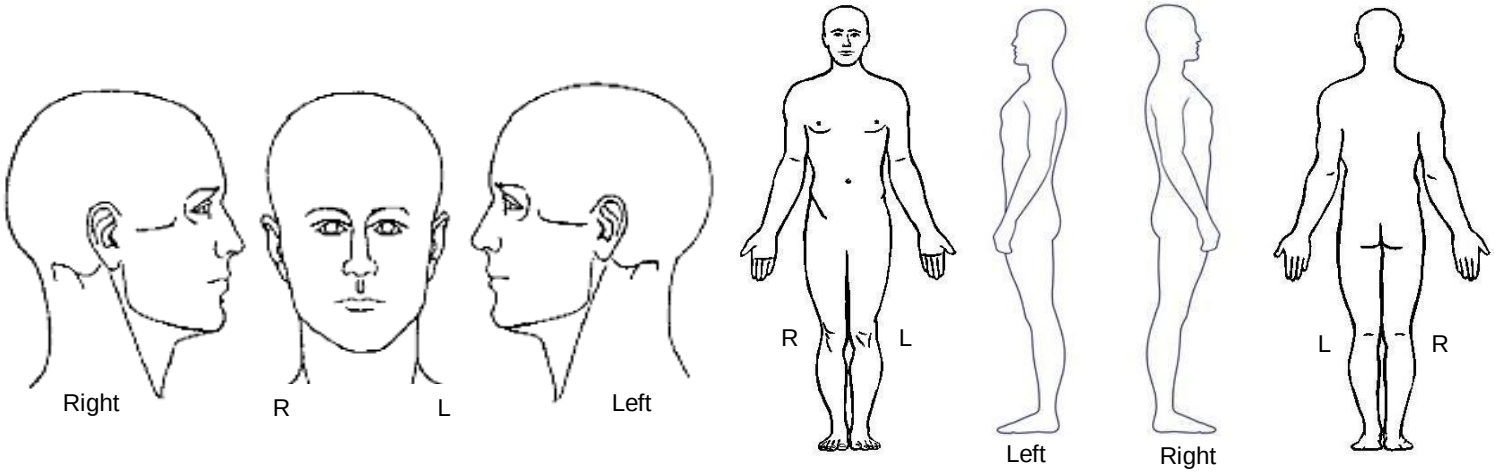
_____

_____

_____

_____

PAIN DESCRIPTION: Please mark the locations on the body diagrams where you are feeling any pain:



Pain has many aspects, such as: sudden or gradual onset; sharp and stabbing or dull and aching; constant or coming and going; severe, moderate or mild. **DESCRIBE YOUR PAIN:**

_____

_____

_____

_____

WHAT OTHER OVERALL HEALTH CONCERNS SHOULD WE KNOW ABOUT? (i.e., family health history, prior diseases, injuries or surgeries):

_____

_____

_____

DO YOU ANY HAVE ANY SPECIAL SENSITIVITIES TO NEEDLING? Describe:_____

ARE YOU PREGNANT? YES NO _____

All client personal information will be held confidential within lawful limits

(OVER PLEASE)

THIS SIDE OF THE FORM IS OPTIONAL *BUT COMPLETING IT WILL HELP YOUR PRACTITIONER(S) HAVE A MORE COMPLETE PICTURE OF YOUR NEEDS.*

PLEASE LIST ANY MEDICATIONS and SUPPLEMENTS you are currently taking (prescribed and over-the-counter, herbs, vitamins, etc…):

Medication/ Supplement: _____ Purpose: _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

CURRENT HEALTH: (**circle anything that you are experiencing;** and talk to the practitioner about how long any symptoms have been occurring)

Temperature: Fever Chills Night sweats Hot Flashes Spontaneous Day sweats ***Do you tend to be thirsty?*** *Yes No*

Circulation: Palpitations Cold Extremities High Blood Pressure Chest Pain Swelling of Ankles Stroke

Heart Murmurs Pacemaker Other_____

Digestion: Changes in Appetite Nausea/Vomiting Heartburn Belching Gas Abdominal Pain

Bowel movements: Frequency _____/day _____/ week Formed / Loose / Liquid (diarrhea) Strained Incomplete

Urination: Dark yellow / Light yellow / Clear Scant / Copious Urgent Frequent Painful Night-time

Breathing: Coughing Wheezing Shortness of Breath Other_____

Head, Eye, Ear, Nose, and Throat: Headaches Eye Pain/Strain Tearing/Dryness Ear Ringing Earaches Sinus Problems

Nose Bleeds Frequent Sore Throats TMJ/Jaw Problems Other_____

Sleep: Hours per night_____ Insomnia Excessive sleepiness Frequent / vivid dreams Other_____

Mental State: Irritability Anxiety Depression Mood Swings Other_____

Energy and Immunity: Fatigue Slow Wound Healing Chronic Infections Allergies (describe)_____

Is your immunity reduced due to HIV, Hepatitis C, chemotherapy or another auto-immune disease? **YES** **NO**

(If yes, describe)_____

Reproductive: Irregular Cycles Breast Lumps/Tenderness Nipple Discharge Vaginal Discharge (describe)_____

PMS Heavy Flow Bleeding Between Periods Painful Periods Other_____

Age of First Menses:_____ # of Days of Menses:_____ Length of Cycle:_____ days

Total # of Pregnancies:_____ # Live births _____ Age at onset of Menopause: _____

Sexual Difficulties Prostrate Problems Testicular Pain/Swelling Penile Discharge Other_____

Neurologic: Dizziness Paralysis Numbness/Tingling Loss of Balance Seizures/Epilepsy Other_____

Skin: Rashes Hives Acne Eczema Sores/Wounds Other_____

Use this area to expand on the items above or list additional items:_____

_____

(OVER PLEASE)

_____