



# Acupuncture and Oriental Medicine

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*Blending Ancient Eastern Medicine* WITH WESTERN MEDICAL EXPERIENCE

## YOUR HEALTH HISTORY

Please complete your health history and bring it to your first appointment with Brenda.

Name \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ Zip Code \_\_\_\_\_

Phone(H) \_\_\_\_\_ Cell \_\_\_\_\_ Work \_\_\_\_\_ Birthdate \_\_\_\_\_

Occupation \_\_\_\_\_ Referred by \_\_\_\_\_

E mail \_\_\_\_\_

Insurance Co \_\_\_\_\_ Physician \_\_\_\_\_ Clinic \_\_\_\_\_

Notify in case of emergency \_\_\_\_\_ Phone \_\_\_\_\_

**Reason for acupuncture treatments** \_\_\_\_\_

### Medical History:

Surgeries, Significant Traumas, Illnesses and Western Medical Diagnosis

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### Prescription Medications:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### Other over the counter medications and nutritional supplements:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### Family Medical History (circle where appropriate, indicate family member)

- |          |                   |                       |
|----------|-------------------|-----------------------|
| Diabetes | Heart Disease     | Cancer                |
| Stroke   | Allergies         | High blood pressure   |
| Seizures | Drug and/or       | Mental illness        |
| Asthma   | Alcohol addiction | Gall bladder problems |

Do you have a pacemaker?

Do you have any bleeding disorders?

Energy	Occasional	Frequent	Sleep	Occasional	Frequent
Fatigue (morning)			Trouble falling asleep		
Fatigue (afternoon)			Wake up a lot		
Fatigue (evening)			Wake early		
			Pleasant dreams		
			Unpleasant dreams		

Name \_\_\_\_\_

<b>Hot/Cold</b>	Occasional	Frequent		Occasional	Frequent
General warmth			General cold/chills		
Night sweats			Cold hands/feet		
Warm at night			Thirsty for cold		
Perspire easily			Thirsty for hot		

<b>Emotions</b>	Occasional	Frequent		Occasional	Frequent
Stress/anxiety			Dull/unclear thinking		
Panic attacks			Indecisive		
Worry			Poor memory		
Fearful			Obsessive		
Phobias			Bipolar		
Depressed			Manic tendencies		
Irritable			Grief		

<b>Head/eyes/ears</b>	Occasional	Frequent		Occasional	Frequent
Eyes:(circle) blurry, itchy, dry, red, floaters			Post nasal drip		
Sinus congestion			Dry mouth		
Sinus headaches			Jaw pain		
Sore throat			Dental problems		
Colds			Mouth sores		
Tension headaches			Seizures		
Migraines			Dizziness		
Lump in throat			Ears ringing		

<b>Chest/Lung/Heart</b>	Occasional	Frequent		Occasional	Frequent
Cough			Heart races		
Asthma			Heart skips		
Chest colds			Heart murmur		
Chest pain			Hard to breathe		

<b>Digestion</b>	Occasional	Frequent		Occasional	Frequent
Bloating			Hard stools		
Belching			Constipation		
Reflux			Loose stools		
Gas			Watery stools		
Nausea			Vegetarian		
Vomiting			Special diet		
Good appetite			Weight gain		
Poor appetite			Weight loss		
Abdominal cramps			Prolapsed organs		
Hemorrhoids			Pain under ribs		
			Tired after eating		

<b>Limbs/Back</b>	Occasional	Frequent		Occasional	Frequent
Muscles weak			Spasms		
Lump/bumps			Tremors		
Upper back pain			Stiff neck		
Mid back pain			Stiff joint		
Low back pain			Swollen feet		
Tingling			Knee pain		
Numbness			Weak knees		
			Joint pain		

Name \_\_\_\_\_

Please list areas of pain in more detail

<b>Women</b>	Occasional	Frequent		Occasional	Frequent
Regular period			Cysts/fibroids		
Irregular period			Vaginal discharge		
Cramps			Yeast infection		
Breast pain			Genital sores		
PMS			Genital warts		

Could you be pregnant now? (circle) Yes No      Number of pregnancies \_\_\_\_\_

# live births:      # miscarriages      # abortions      # premature births      # C sections

**Periods:**

Age started \_\_\_\_\_ Flow (number of days): \_\_\_\_\_ Length of cycle \_\_\_\_\_

Flow (circle one) Light Medium Heavy Blood clots (circle one) No Some Many      Age of menopause \_\_\_\_\_

<b>Men</b>	Occasional	Frequent		Occasional	Frequent
Genital rash/itch			Sexual dysfunction		
Genital pain			Prostate problems		

<b>Urine</b>	Occasional	Frequent		Occasional	Frequent
Frequent			Burning urine		
Up at night			Can't control		
Cloudy			Infections		

<b>Miscellaneous</b>	Occasional	Frequent		Occasional	Frequent
Bruise easily			Skin rash		
Acne			Skin lesions		
Premature gray			Alcohol		
Tobacco			Street drugs		