Silver Leaf Acupuncture: Patient Health History Form

Today's Date:	
Name (first, last):	DOB:
Address (street):	Gender: Female or Male
Address (town, state):	Phone #:
Email address:	Occupation:
Emergency Contact (name, number):	
Primary care physician:	
How did you hear about us?	

Reason for making acupuncture appointment

Reason for making initial appointment:	
When did it start?	Severity: 1 (minimal) ---------- 10 (high)
What makes it better and worse:	

Lifestyle:

Cups of water/day:	Caffeine/day:
Alcohol/day/week:	Tobacco and marijuana:
What do you eat regularly: Breakfast:	
Lunch:	
Dinner:	
Exercise routine:	Energy level 1 (low) – 10 (high):
Emotions: happy, sad, anxious, shy/timid, worried, angry, irritable	Time of sudden energy drop:
Current medication/vitamins/supplements:	

Personal Medical History:

Asthma	Seizure/fainting	Cancer	Stroke
Heart disease	High or low blood pressure	Edema	Hepatitis
Thyroid disease	Sexually transmitted disease	Crohn's	Diverticulitis
Ulcerative colitis	Gallbladder disease/removal	Kidney stones	Weight gain or loss
Psoriasis/eczema	Rheumatoid arthritis	Diabetes	High cholesterol
Injury, surgery, hospitalization:			
Allergies:			

Body temperature:

Cold ----------neutral----------hot Cold hands and feet?	Night sweats:
	Hot flashes:
	Sweat easily:

Sleep:

# Hours/night	Difficulty falling asleep	Wake to urinate
	Difficulty staying asleep *What time(s) do you wake?*	Rested in AM

Headaches:

Location	Dull	Throbbing	Sharp	Heavy
Migraine	TMJ pain	Dizziness	Vertigo	Poor memory
Poor vision	Floaters	Dry or Itchy eyes	Ringing ears	Cataracts

Mouth and throat:

Thirst for cold or warm drinks	Dry mouth	Bleeding gums	Unusual taste	Sore throat

Respiratory:

Prone to colds	Chronic cough	Color of phlegm	Difficult breathing
Pneumonia	Bronchitis	Asthma	COPD/Emphysema

Digestion:

Gas after meals	Bloating	Full easily	Indigestion
Strong or Low appetite	Acid reflux	Stomach pain	Nausea /vomit

Bowel movements:

# Bowel/day	Formed or loose	Diarrhea	Constipation	Hemorrhoid
	Blood	Mucus	IBS	Foul smelling

Urination:

Frequent	Incontinence	Dribbling	Wake at night	Color of urine
Clouded	Blood	Burning	Strong odor	

OB/GYN:

Date of last menses:

Pregnant	# Live births	# Miscarriages	Irregular cycle
Birth control	Age of 1st period	Length of period	Length of cycle *(start to start)*
Cramps/Painful periods	List PMS symptoms	Headache/period	Fatigue/period

Quality of blood (thin, thick, clots)	Color of blood (pale, bright, dark, brown, purple)	Bleeding between periods

Vaginal discharge	Yeast infection	Endometriosis	STD
Cyst	Fibroid	Hysterectomy	HPV

Menopause:

How old	Hot flashes	Night sweats	Vaginal dryness	Osteoporosis

Men reproduction:

Loss of sex drive	Impotence	Prostate cancer	Testicular pain/swelling

Pain: Shade area(s) of pain:

Better/worse with heat/cold	
Better/worse with movement	
Better/worse with pressure