

## 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 use:
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	Night sweats:
Cold hands and feet?	Hot flashes:
	Sweat easily:

**Sleep:**

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

**Headaches:**

<b>Location</b>	<b>Dull</b>	<b>Throbbing</b>	<b>Sharp</b>	<b>Heavy</b>
<b>Migraine</b>	<b>TMJ pain</b>	<b>Dizziness</b>	<b>Vertigo</b>	<b>Poor memory</b>
<b>Poor vision</b>	<b>Floaters</b>	<b>Dry /itchy eyes</b>	<b> ringing ears</b>	<b>Cataracts</b>

**Mouth and throat:**

<b>Thirst for Cold or warm</b>	<b>Dry mouth</b>	<b>Bleeding gums</b>	<b>Unusual taste</b>	<b>Sore throat</b>

**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/low appetite	Acid reflux	Stomach pain	Nausea /vomit

**Bowel movements:**

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

**Urination:**

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

**OB/GYN:**

Pregnant	# Live births	# Miscarriages	Irregular cycle
Birth control	Age of 1 <sup>st</sup> period	Length of period	Length of cycle <i>(start to start)</i>
Painful periods	PMS symptoms	Headache/period	Fatigue/period

**Date of last menses:**

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:**

Age of menopause	Hot flash	Night sweat	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	

