

Silver Leaf Acupuncture: Patient Health History Form

| | | |
|-----------------------------------|--|------------------------|
| Name (first, last): | | DOB: |
| Address (street): | | Gender: Female or Male |
| Address (town, state): | | Phone #: |
| Email address: | | Occupation: |
| Emergency Contact (name, number): | | |
| Primary care physician: | | |

Main Complaint:

| | |
|---------------------------------|---------------------------------------|
| Main complaint: | |
| 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: |
| Diet (breakfast, lunch, dinner): | |
| Exercise routine: | Energy level 1 (low) – 10 (high): |
| Emotions: happy, sad, anxious, shy/timid, worried, angry, irritable | Sudden Energy drop: |
| Current medication/vitamins/supplements: | |
| Injury, surgery, hospitalization: | |
| Allergies: | |

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 |

Body temperature:

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

Sleep:

| | | |
|---------------|---------------------------|-----------------|
| # Hours/night | Difficulty falling asleep | Wake to urinate |
| | Difficulty staying asleep | Rested in AM |

Headache, eyes, ears:

| | | | | |
|--------------------|-----------------|------------------------|---------------------|--------------------|
| Location | Dull | Throbbing | Sharp | Heavy |
| | | | | |
| Migraine | TMJ pain | Dizziness | Vertigo | Poor memory |
| | | | | |
| Poor vision | Floaters | Dry /itchy eyes | Ringing ears | Cataracts |
| | | | | |

Mouth and throat:

| | | | | |
|-----------------------------|------------------|----------------------|----------------------|--------------------|
| Thirst (cold or hot) | Dry mouth | Bleeding gums | Unusual taste | Sore throat |
| | | | | |

Chest:

| | | | |
|-----------------------|----------------------|------------------------|----------------------------|
| 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 1st period | Length of period | Length of cycle (start to start) |
| | | | |
| Painful periods | 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:

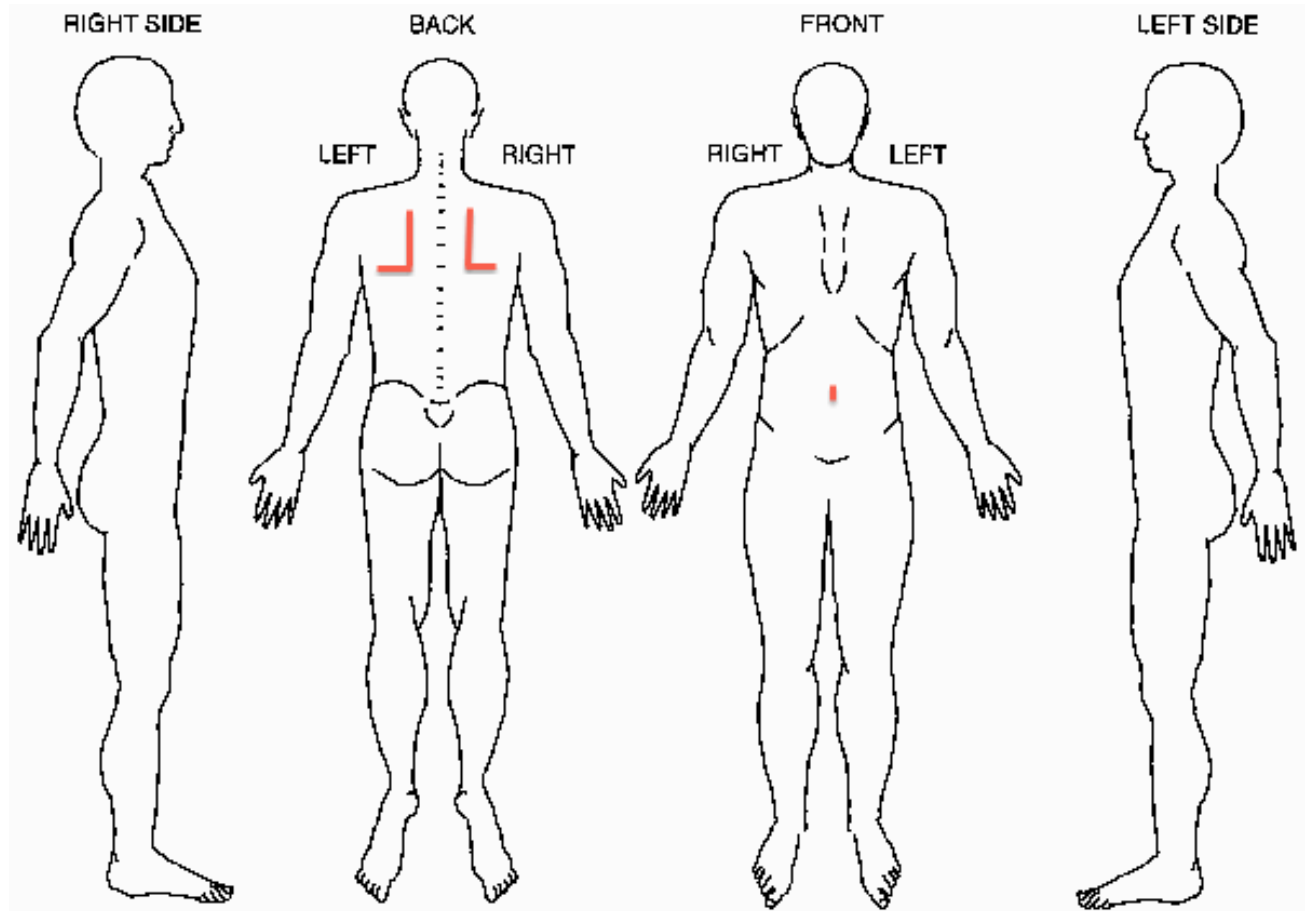
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|-------------------------|------------------|--------------------|------------------------|---------------------|
| Age of menopause | Hot flash | Night sweat | Vaginal dryness | Osteoporosis |
| | | | | |

Men reproduction:

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|--------------------------|------------------|------------------------|---------------------------------|
| 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 | |



(For the acupuncturist to complete)

Initial Diagnosis:

Initial Treatment:

Initial Treatment Plan: