Ageless Acupuncture Patient Health History

Name: _____ Date: _____

By what name would you like us to refer to you?:_____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Home Telephone: _____ Work Telephone: _____

Cell Phone: _____ How early/late may I call you? _____

Email Address: _____ May I send you information by email? Y N

Date of Birth: _____ Gender: M F **Marital Status:** S M D W SO Separated

Emergency Contact: _____ Telephone: _____
Relationship: _____

1. **Are you currently receiving health care?** Y N

2. **Do you have a pacemaker?** Y N

3. **Please identify the health concerns that have brought you to the clinic today:**
   Condition Past Treatment/Impact on Quality of Life

   a. _____

   _____

   b. _____

   _____

   c. _____

   _____

   d. _____

4. **Do you have any reason to believe you are pregnant?** Y N

5. **Height: _____ Weight: _____ Max Weight: _____ When: _____**

6. **Childhood Illness** (please circle any you have had):
Scarlet Fever Diphtheria Rheumatic Fever Mumps Measles Chicken Pox

7. **Immunizations** (please circle any you have had):
Polio Tetanus Measles/Mumps/Rubella Pertussis Diptheria Hepatitis B
Other

8. **Do you have any chronic infectious diseases?** Y N

If yes, please explain: _____

9. **Are you currently suffering from any chronic illness?** Y N

If yes, please explain: _____

10. **Severe Illnesses:** _____

11. **Please list all allergens, foods, drugs, and medications you are hypersensitive or allergic to and the type of reaction:** _____

_____

12. **Please list all prescription medications (and their purposes) that you are currently taking:**

Medication	Date started	Reason for taking	Any side effects

13. **Please list all over-the-counter medications, vitamins, and supplements that you are currently taking: (Include antacids, cold/flu, sleep, allergy and pain medications)**

Supplement	Date started	Reason for taking	Any side effects

14. **Hospitalizations and surgeries:**

Reason	When	Reason	When

15. **X-Rays/CAT Scans/MRI's/Special studies**:

Reason	When	Reason	When

Current Primary Care Physician: _____ Date last seen: ___/___/___ Reason: _____
Clinic name: _____ Phone: _____
Address: _____ Fax: _____
City/State/Zip: _____

Other Healthcare practitioners
Type: (L.Ac., DC, LMT, ND, etc) Phone/Fax:

Describe your ideal doctor or healthcare provider: _____
_____
_____

Coping techniques for dealing with stress: _____

16. **Family History:**

	Mother	Father	Siblings	Spouse	Children
Deceased (Y/N)					
Cause of death					
Age					
Health (G=good, P=Poor)					
Check any conditions that family members have had:					
Cancer					
Diabetes					
Heart Disease					
High Blood Pressure					
Stroke					
Mental Illness					

Please CIRCLE current, UNDERLINE past experiences

17. **Emotional**

Mood Swings Nervousness Mental Tension

18. **Energy and Immunity**

Fatigue/Chronic Fatigue Syndrome Slow Wound Healing

19. **Head, Eye, Ear, Nose, Throat**

Impaired Vision Eye Pain/Strain Glaucoma Glasses/Contacts Tearing/Dryness

Impaired Hearing Ear Ringing Earaches Headaches Sinus Problems

Nose Bleeds Teeth Grinding Frequent Sore Throats TMJ/Jaw Problems

Hay Fever

20. **Respiratory**

Pneumonia Frequent Common Colds Difficulty Breathing Emphysema

Persistent Cough Pleurisy Asthma Tuberculosis

Shortness of Breath Other:

21. **Cardiovascular**

Heart Disease Chest Pain Swelling of ankles High Blood Pressure

Palpitations Stroke Heart Murmurs Rheumatic Fever

Varicose Veins

22. **Gastrointestinal**

Ulcers Changes in Appetite Nausea/Vomiting Abdominal Pain

Heartburn Belching Liver Disease Hepatitis B or C

Hemorrhoids

23. **Stool**

Diarrhea Constipation Undigested Food Mucous or Blood in stool

24. **Genito-Urinary Tract**

Kidney Disease Painful Urination Frequent Urinary Tract Infections

Frequent Urination Venereal Disease Kidney Stones Impaired Urination Urination at night

Blood in Urine Incontinence

25. **Female Reproduction**

Irregular cycles Breast lumps/tenderness Nipple Discharge Heavy Flow

Clotting Bleeding between Cycles Vaginal Discharge

Premenstrual Problems Menopausal Symptoms Post Menopause

Difficulty Conceiving Pain with Intercourse

26. **Menstrual/Birthing History**

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

Birth Control Now: _____ Birth Control Use in the Past: _____

# of Pregnancies: _____ # of Miscarriages: _____ # of Abortions: _____ # of Live Births: ____

Are You Fertile? Y N Age at Menopause _____ Vaginal Discharge

27. **Male Reproductive**

Sexual Difficulties Prostrate Problems Testicular Pain/Swelling Penile Discharge

Pain with Intercourse

28. **Musculoskeletal**

Neck/Shoulder Pain Muscle Spasms/Cramps Arm Pain Upper Back Pain Mid Back Pain

Low Back Pain Leg Pain Joint Pain Where: _____

29. **Neurologic**

Vertigo/Dizziness Paralysis Numbness/Tingling Loss of Balance Seizures/Epilepsy

30. **Endocrine**

*Hypo*thyroid *Hyper*thyroid *Hypo*glycemia Diabetes Mellitus Night Sweats

Feeling Hot or Cold Hot Flashes

31. **Other**

Anemia Cancer Rashes Eczema/Hives Cold Hands/Feet

32. **Lifestyle**

A. **Food intake for yesterday:**

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

B. **Exercise:** _____

C. **When do you go to sleep? _____ When do you awake? _____**

D. **Do you have vivid dreams/nightmares: _____**

E. **Occupation: _____** Employer: _____

Hours/week: _____

Do you enjoy work? Y N Why/Not? _____

F. **Nicotine/Alcohol/Caffeine/Recreational drug use: _____**

How Often? _____

G. **Have you experienced any major traumas (emotional, spiritual, physical):** Y N

Please explain: _____

H. **Consumption of Liquids**

Type of fluid: _____ Amount per day: _____

I. **Television Habits: _____**

J. **Reading Habits: _____**

K. **Interests and Hobbies: _____**

How did you hear of Ageless Acupuncture? _____

Thank you for taking the time to fill out this form. I appreciate that this is a time investment for you and I want you to know that I use all of this information to arrive at my diagnosis and treatment plan.

Cheryl McCarthy, L.Ac.