Acupuncture Medical History Form

Name:	Date of Birth:	Gender: ☐ Female ☐ Male
Main Problem:		Onset:
Other Concurrent Therapies:		

Past Medical History (include date):

Significant Illnesses:

☐Cancer ☐Diabetes ☐High Blood Pressure ☐Heart Disease ☐Hepatitis ☐Rheumatic Fever ☐Thyroid Disease ☐Seizures ☐Other

Surgeries:_____
Significant Trauma (auto accidents, falls, etc): _____
Birth History (prolonged labor, forceps delivery, etc.): _____
Allergies (drugs, chemical, foods): _____
Medicines taken within last two months (vitamins, over-counter drugs, herbs, etc): _____
_____
Occupational Stresses (chemical, physical, psychological, etc): _____
Exercise: _____
Comments: _____

Average Daily Diet: Morning Afternoon Evening

Habits: ☐Cigarettes ☐Coffee ☐ Tea ☐Cola ☐Alcohol ☐Drugs ☐Sugar ☐Salt ☐Other: _____

Family Medical History: ☐Cancer ☐Diabetes ☐High Blood Pressure ☐ Heart Disease ☐Stroke
☐Asthma ☐Allergies ☐Alcoholism ☐Other: _____

Notes: _____
_____

General

☐Poor Appetite	☐Heavy Appetite	☐Poor Sleep	☐Heavy Sleep	☐Insomnia
☐Fatigue	☐Tremors	☐Vertigo	☐Cold Hands	☐Cold Feet
☐Cold Back	☐Cold Abdomen	☐Fevers	☐Chills	☐Night Sweats
☐Sweat Easily	☐Cravings	☐Localized Weakness	☐Poor Coordination	☐Change in Appetite
☐Sudden Energy Drops	☐Peculiar Taste	☐Peculiar Smell	☐Strong Thirst	☐Bleed/Bruise Easily
Time:				Where?

Skin & Hair

☐Rashes	☐Ulcerations	☐Hives	☐Itching	☐Eczema
☐Pimples	☐Dandruff	☐Loss of Hair	☐Change in hair/skin	☐Purpura
☐Other Hair/Skin Issue:				

Head, Eyes, Ears, Nose & Throat

☐Dizziness	☐Concussions	☐Migraines	☐Glasses	☐Eye Strain
☐Eye Pain	☐Poor Vision	☐Night Blindness	☐Color Blindness	☐Cataracts
☐Blurry Vision	☐Earaches	☐Ringing in Ears	☐Poor Hearing	☐Nose Bleeds
☐Sinus Problems	☐Mucus	☐Dry Throat	☐Dry Mouth	☐Copius Saliva
☐Teeth Problems	☐Jaw Clicks	☐Grinding Teeth	☐Facial Pain	☐Gum Problems
☐Spots in Eyes	☐Recurrent Sore Throat	☐Sores on Lips/Tongue	☐Headaches	☐Other neck/head issue
Where/When?		Where/When?		

Cardiovascular

□High Blood Pressure	□Low Blood Pressure	□Chest Pain	□Irregular Heartbeat	□Dizziness
□Fainting	□Cold Hands/Feet	□Swelling in hands/feet	□Blood Clots	□Phlebitis
□Difficulty Breathing	□Other:			

Respiratory

□Cough	□Coughing Blood	□Asthma	□Bronchitis	□Pneumonia
□Difficulty breathing when laying down		□Tight Chest	□Production of phlegm _____ color _____	
□Other Lung Issues:				

Gastrointestinal

□Nausea	□Vomiting	□Diarrhea	□Gas	□Belching
□Black Stools	□Bad Breath	□Rectal Pain	□Hemorrhoids	□Constipation
□Bloody Stools	□Sensitive Abdomen	□Pain or Cramps	□Laxative Use: /week; type	
□Bowel Movement	Frequency:	Color:	Odor:	Texture/Form:

Genito-Urinary

□Pain with Urination	□Frequent Urination	□Blood in Urine	□Urgency to Urinate	□Unable to withhold
□Kidney Stones	□Venereal Disease	□Impotency	□Wake up to Urinate /night	
□Other G/U Issues:				

Pregnancy and Gynecology

□Pregnancies # ____	# Births ____	□Premature Births	□Miscarriages	□Age at first Menses
□Period Duration (days) ____		□Irregular Periods	□Flow (describe)	□Clots
□Last Pap ____	□Last Menses	□Vaginal Discharge	□Vaginal Sores	□Breast Lumps
□Menopause	□Birth Control (type/duration):		□Changes in body/psyche prior to menstruation	

Musculoskeletal

□Neck Pain	□Muscle Pains	□Back Pain (where)	□Joint Pains (where)
□Other Joint or Bone Issues			

Neuropsychological

□Seizures	□Areas of Numbness	□Poor Memory	□Concussion	□Depression
□Anxiety	□Bad Temper	□Easily Stressed	□Treated for Emotional Problems	
□Other Neurological or Psychological Issues:				

Classical

Preference	Most Liked	Least Liked
Season		
Taste		
Climate		
Time of Day		
Temperature		

Body Type: _____
Color/Tone: _____
Odor: _____
Yin/Yang: _____
Firm/Weak: _____
Hot/Cold: _____
Surface/Interior: _____

Comments: