ACUPUNCTURE HEALTH INFORMATION FORM

Name: ________________________________

Have you experienced ACUPUNCTURE? ❑No ❑Yes If yes, then was your last treatment? ___/___/___ What goal(s) do you want achieve with acupuncture? ___________________________

Are you currently receiving other doctor, medical practitioner, or psychological care? ❑No ❑Yes If yes, please give name(s) of your provider(s) and reason(s): ________________________________

Do you have your physician's approval to receive massage and/or acupuncture? ❑No ❑Yes ❑Not Applicable

Have you experienced CUPPING? ❑No ❑Yes I understand I can review ***Cupping & Gua Sha Information*** on website.

May we share, CONSULT, and/or COLLABORATE about your specific case with mutual practitioner(s) in this clinic? **❑No ❑Yes** Practitioner Name(s):______________________________

_____Initials

BALANCED BODY
THERAPEUTICS

Health Information & Medical History

Have you had any recent colds, illnesses? ❑No ❑Yes Comments:

Do you have allergies to scents, lotions, or oils? ❑No ❑Yes If yes, please list:

Diagnostic Screenings

Do you have high blood pressure (>145/95)? ❑Yes ❑No Controlled? ❑Yes ❑No Today _____/_____

❑Autoimmune: _______________/___/___❑Cancer: _______________/___/___❑Diabetes: ___/___/___

❑Hepatitis: ___ ___/___/___ ❑High Cholesterol: _________/___/___ ❑HIV: ___/___/___ ❑TB: ___/___/___

❑Thyroid: _______________/___/___ ❑Other: _______________/___/___

Describe your current exercise regimen: Did you exercise today? ❑Yes ❑No *Activities:* ❑Aerobics ❑Dance/Martial Arts ❑Interval / Strength training ❑Yoga / Flexibility ❑Race / Game Effort ❑Casual Activity: _________________ ❑Physical Therapy

******For Women Only******

Are you pregnant? ❑No ❑Unsure ❑Yes ______months Are you menstruating? ❑Yes ❑No

Number of days your cycle lasts? ____ Number of days between cycles? ____

Bleeding between cycles? ❑Yes ❑No Describe amount and quality of your blood during your cycle?

____

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Nutrition

Please list current nutritional supplements, herbs, or medications:

____

Do you follow a special diet? ❑Yes ❑No If yes, how would you describe your diet/how you eat?

____

Tastes you tend to crave: ❑Bitter ❑Sweet ❑Pungent/Savory ❑Salty ❑Sour ❑Combination of Flavors/Textures: ____

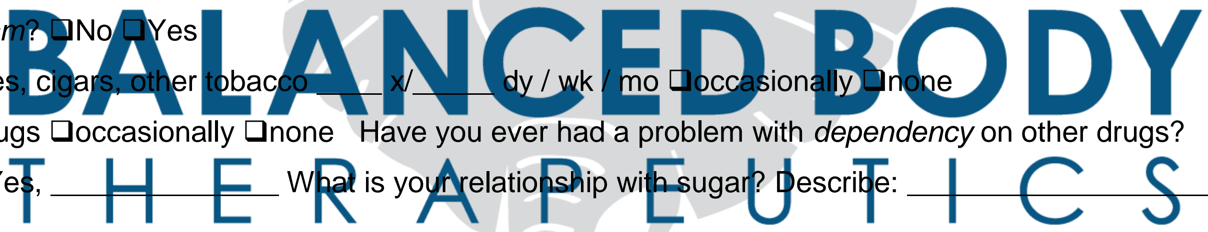
Foods you dislike/allergic to: ____

Do you tend drink ❑Hot ❑Cold ❑Room Temperature food / fluids? Do you keep water by your bed? ❑Yes ❑No

Do you use any of the following?

Coffee, tea, soft drinks____ x per dy / wk / mo ❑occasionally ❑none

Alcohol ___x per dy / wk / mo ❑occasionally ❑none Have you ever had a problem with *alcohol* or *alcoholism*? ❑No ❑Yes



Cigarettes, cigars, other tobacco _____ x/______ dy / wk / mo ❑occasionally ❑none

Other drugs ❑occasionally ❑none Have you ever had a problem with *dependency* on other drugs? ❑No ❑Yes, ____________ What is your relationship with sugar? Describe: ______________

Medical History

Please list hospital visits/stays, traumatic injuries, automobile accidents and surgeries with approximate dates: ____

Please check all that historically and currently apply. Circle choices where presented:

General	***Skin & Hair***	***Head & Neck***
❑Appetite good / fair / poor ❑Insomnia ❑Fatigue ❑Fevers / chills ❑Night sweats ❑Localized weakness ❑Poor Coordination ❑Bleed / bruise easily ❑Catch cold easily ❑Other: ______________________	❑Rashes / hives ❑Itching ❑Eczema ❑Pimples ❑Dryness ❑Herpes / shingles ❑Athlete's foot / warts ❑Other: ______________________	❑Dizziness ❑Fainting ❑Stiffness ❑Enlarged lymph glands ❑Headaches ❑Migraines ❑Concussions ❑Other: ______________________
Eyes	***Ears, Nose, Throat***	***Cardiovascular & Circulatory***
❑Blurred vision ❑Inflamed / dry eyes ❑Poor night vision ❑Spots / "floaters" ❑Cataracts ❑Glaucoma	❑Infection ❑Tinnitus "ringing" / "high tone / low tone" ❑Decreased hearing ❑Nose bleeds ❑Sinus infections	❑Low blood pressure ❑Blood clots ❑Palpatations "skip beats / flip flop" ❑Phlebitis ❑Chest pain ❑Irregular heartbeat

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***Eyes* Continued…** ❑Glasses / contacts ❑Other: ____________________	***Ears, Nose, Throat* Continued…** ❑Hay fever / allergies ❑TMJ / jaw pain ❑Difficulty swallowing ❑Other: ____________________	***Cardiovascular & Circulatory Continued…*** ❑Cold hands / feet / both ❑Varicose veins ❑Lymphedema ❑Other: ___________________
Respiratory ❑Asthma ❑Bronchitis ❑COPD ❑Pneumonia ❑Cough dry / productive ❑Coughing blood / blood streaked ❑Other: ____________________	***Gastro-Intestinal*** ❑Nausea ❑Belching / indigestion ❑Vomiting ❑Diarrhea / constipation ❑Stool with blood / black tarry ❑Bad breath ❑Rectal pain ❑Hemorrhoids bleeding / painful ❑Pain / cramps ❑Gall bladder disorder ❑Gas / bloating ❑Other: ____________________	***Male*** ❑Pain / itching genitalia ❑Hernia / lumps ❑Nocturnal / frequent urination ❑Weak urinary stream ❑Other: ____________________ ***Female*** ❑Pain / itching genitalia ❑Frequent urinary infection (UTI) ❑Frequent vaginal infection ❑Irregular menstrual cycle ❑Painful menstrual cycle ❑PMS ❑Menopausal syndrome ❑Hot flashes ❑Breast lumps ❑Other: ____________________
Neurological ❑Seizures ❑Tremors ❑Numbness / tingling of limbs ❑Concussion ❑Pain ❑Paralysis ❑Other: ____________________	***Psychological*** ❑Addiction ❑Depression ❑Stress / anxiousness ❑Irritability ❑Poor concentration ❑Therapy for: ❑Other: ____________________	***Muscular-Skeletal*** ❑Chronic pain ❑Stiff neck / shoulders ❑Low back pain ❑Back pain ❑Scoliosis ❑Muscle spasm / twitching / cramps ❑Sore, cold / weak knees ❑Joint pain ❑Tendon / Ligament strain / tears ❑Stress fracture / broken bones ❑Osteopenia / osteoporosis ❑Tendonitis / Bursitis ❑Other: ____________________

Other information you feel is important for me to know or we discussed: ________________________

____

____

SIGNATURE AND DATE

The foregoing information is true and correct to the best of my knowledge. I will notify my practitioner of any changes that occur in my current health status.

Patient Signature: _________________________________ Date: ____/____/____

Printed Name of Parent/Guardian: _________________________________ Date: ____/____/____