Acupuncture Health & Wellness

Patient Medical History

Name: _____ Date: _____

What brings you to our office today (chief complaint): _____

_____

Other present medical conditions? _____

_____

Surgeries (list all surgeries, dates and any complications): _____

_____

Scars (please list scars, approximate dates and where located): _____

_____

Please list any **Accidents and Traumas** (dates and brief description): _____

_____

_____

List childhood illnesses (i.e. strep throat, mono, chicken pox, etc.)**:** _____

_____

List current medications and/or supplements: _____

_____

The following information is essential for the diagnosis procedure. Additionally, it helps me to provide a better treatment. Please fill it out as accurately as possible.

☐ Pacemaker ☐ Seizure disorder ☐ Bleeding disorder ☐ High blood pressure

☐ Diabetes/Hypoglycemia ☐ Believe you are or may be pregnant

Please note all major illnesses in your immediate family (such as diabetes, heart disease, high blood pressure, neurological disorders, psychological disorders, blood disorders, orthopedic disorders, etc.) _____

_____

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Please mark any symptoms that apply to you:

Liver & Gallbladder Channel

☐ Anger/irritability/temper ☐ Blurry vision/spots ☐ Breast tenderness ☐ Brittle/coarse nails/hair
☐ Bruising easily ☐ Depression ☐ Distention/bloating ☐ Eye/vision problems ☐ Flatulence
☐ Headaches/Migraines ☐ Hemorrhoids ☐ Indigestion ☐ Irritable bowel ☐ Menstrual irregularity
☐ Nausea/vomiting ☐ PMS ☐ Stiff neck/shoulders ☐ Tension/cramps ☐ Tinnitus (high pitch)

Heart & Small Intestine Channel

☐ Abdominal pain ☐ Anemia ☐ Anxiety/dread ☐ Digestive troubles ☐ Dream-disturbed sleep
☐ Elbow/shoulder pain ☐ Hearing problems ☐ Heart problems ☐ Hot flashes ☐ Hot, painful joints
☐ Insomnia/Sleep problems ☐ Lack of joy/humor ☐ Mouth/tongue sores ☐ Muscle tone, poor
☐ Palpitations ☐ Poor circulation ☐ Restless ☐ Tongue/speech ☐ Upper back pain ☐ Urinary problems

Spleen & Stomach Channel

☐ Abdominal pain ☐ Aching/heavy limbs ☐ Anemia ☐ Appetite/digestive problems ☐ Belching
☐ Bruise easily ☐ Colic/indigestion ☐ Difficult to focus ☐ Distention/bloating ☐ Dyspepsia
☐ Gastritis ☐ Headaches ☐ Hiccups ☐ Irritable bowel ☐ Lethargy/fatigue ☐ Loose stools
☐ Muscle weakness ☐ Nausea/vomiting ☐ Poor memory ☐ Prolapse ☐ Worry/over thinking

Lung & Large Intestine Channel

☐ Allergies ☐ Arm/shoulder pain ☐ Asthma ☐ Constipation ☐ Cough/sneeze/phlegm
☐ Eczema/psoriasis/rashes ☐ Elbow pain ☐ Fatigue/tiredness ☐ Flatulence ☐ Frequent colds
☐ Frontal/sinus headaches ☐ Grief/sadness ☐ Loose stools ☐ Mucus ☐ Nasal problems
☐ Problems with smell ☐ Sinusitis ☐ Sweating problems ☐ Stiff joints/neck ☐ Weak voice
☐ Wheezing/shortness of breath

Kidney & Bladder Channel

☐ Adrenal weakness ☐ Back/hips/knees pain ☐ Bladder infections/control problems ☐ Brittle bones
☐ Cold hands/feet ☐ Dark/puffy around eyes ☐ Depression/fear ☐ Edema/water retention
☐ Impotence/libido ☐ Infertility/sterility ☐ Lethargy/fatigue ☐ Loss/thinning hair ☐ Poor memory
☐ Prematurely gray ☐ Sciatic/lumbago ☐ Senility ☐ Sore throat in a.m. ☐ Tinnitus (low pitch)
☐ Urine output weak ☐ Will power low

I understand that by not completing this form in full, or by omitting information, that it may affect the efficacy or safety of my treatment. I will update Acupuncture Health & Wellness in writing with regards to any changes in my health or medications. All the above statements are true.

Please sign _____ Date _____