



Patient Health History/ Initial Intake

Name: _____
(first) (middle) (last)

Date: ____/____/____

Date of Birth: ____/____/____

Age: _____

Gender: M/F

Marital status: S M D W

Successful health care and preventative medicine are only possible when the practitioner has a complete understanding of the patient physically, mentally and emotionally. Please complete this questionnaire as thoroughly as possible. Print all information and indicate areas of confusion with a question mark. Thank you.

1. When and where did you last receive health care? _____

For what reason? _____

2. Has your case been referred to an attorney? Y N

3. Please identify the health concerns that have brought you to Central Coast Family Acupuncture in order of importance below:

Condition

Past Treatment

a. _____

How does this condition affect you? _____

b. _____

How does this condition affect you? _____

c. _____

How does this condition affect you? _____

d. _____

How does this condition affect you? _____

4. If applicable, please list any foods, drugs, or medications you are hypersensitive or allergic to (please include reaction):

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5. Please list any medications (prescribed and over-the-counter), vitamins, and supplements you are currently taking:

6. Do you have any reason to believe you may be pregnant? Y N

If so, how far along are you? _____

7. Do you have any infectious diseases? Y N If yes, please identify: _____

8. **Family History:** Father Mother Brothers Sisters Spouse Children

Check those applicable:

Age (if living)	_____	_____	_____	_____	_____	_____
Health (G=Good, P=Poor)	_____	_____	_____	_____	_____	_____
Cancer	_____	_____	_____	_____	_____	_____
Diabetes	_____	_____	_____	_____	_____	_____
Heart Disease	_____	_____	_____	_____	_____	_____
High Blood Pressure	_____	_____	_____	_____	_____	_____
Stroke	_____	_____	_____	_____	_____	_____
Mental Illness	_____	_____	_____	_____	_____	_____
Asthma/Hay fever/Hives	_____	_____	_____	_____	_____	_____
Kidney Disease	_____	_____	_____	_____	_____	_____
Age (at death)	_____	_____	_____	_____	_____	_____
Cause of Death	_____	_____	_____	_____	_____	_____

9. **Height:** _____ **Weight:** Currently: _____ Past Maximum: _____ When? _____

10. **Blood Pressure:** What is your most recent blood pressure reading? _____ / _____ When was this reading taken? _____

11. **Childhood Illness** (please circle any that you have had):

Scarlet Fever Diphtheria Rheumatic Fever Mumps Measles German Measles Chicken Pox

12. **Immunizations** (please circle any that you have had):

Polio Tetanus Rubella/Mumps/Rubella Pertussis Diphtheria Hib Hepatitis B

Others: _____

13. **Hospitalizations and Surgeries:**

Reason When Reason When

14. **X-Rays/CAT Scans/MRI's/NMR's/Special Studies:**

<u>Reason</u>	<u>When</u>	<u>Reason</u>	<u>When</u>
<hr/>		<hr/>	
<hr/>		<hr/>	
<hr/>		<hr/>	

15. **Emotional** (please circle any that you experience now and underline any that you have experienced in the past):

Mood Swings Nervousness Mental Tension

16. **Energy and Immunity** (please circle any that you experience now and underline any that you have experienced in the past):

Fatigue Slow Wound Healing Chronic Infections Chronic Fatigue Syndrome

17. **Head, Eye, Ear, Nose, and Throat** (please circle any that you experience now and underline any that you have experienced in the past):

Impaired Vision Eye Pain/Strain Glaucoma Glasses/Contacts Tearing/Dryness
Impaired Hearing Ear Ringing Earaches Headaches Sinus Problems
Nose Bleeds Frequent Sore Throats Teeth Grinding TMJ/Jaw Problems Hay Fever

18. **Respiratory** (please circle any that you experience now and underline any that you have experienced in the past):

Pneumonia Frequent Common Colds Difficulty Breathing Emphysema
Persistent Cough Pleurisy Asthma Tuberculosis
Shortness of Breath Other Respiratory Problems: _____

19. **Cardiovascular** (please circle any that you experience now and underline any that you have experienced in the past):

Heart Disease Chest Pain Swelling of Ankles High Blood Pressure
Palpitations/Fluttering Stroke Heart Murmurs Rheumatic Fever Varicose Veins

20. **Gastrointestinal** (please circle any that you experience now and underline any that you have experienced in the past):

Ulcers Changes in Appetite Nausea/Vomiting Epigastric Pain Passing Gas Heartburn
Belching Gall Bladder Disease Liver Disease Hepatitis B or C Hemorrhoids Abdominal Pain

21. **Genito-Urinary Tract** (please circle any that you experience now and underline any that you have experienced in the past):

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Kidney Disease Painful Urination Frequent UTI Frequent Urination Heavy Flow
Kidney Stones Impaired Urination Blood in Urine Frequent Urination at Night

22. **Female Reproductive/Breasts** (please circle any that you experience now and underline any that you have experienced in the past):

Irregular Cycles Breast Lumps/Tenderness Nipple Discharge Heavy Flow
Vaginal Discharge Premenstrual Problems Clotting Bleeding Between Cycles
Menopausal Symptoms Difficulty Conceiving Painful Periods

23. **Menstrual/Birthing History:**

1. Age of First Menses: _____ 4. Birth Control Type: _____ 7. # of Abortions: _____
2. # of Days of Menses: _____ 5. # of Pregnancies: _____ 8. # of Live Births: _____
3. Length of Cycle: _____ 6. # of Miscarriages: _____

24. **Male Reproductive** (please circle any that you experience now and underline any that you have experienced in the past):

Sexual Difficulties Prostrate Problems Testicular Pain/Swelling Penile Discharge

25. **Musculoskeletal** (please circle any that you experience now and underline any that you have experienced in the past):

Neck/Shoulder Pain Muscle Spasms/Cramps Arm Pain Upper Back Pain Mid Back Pain
Low Back Pain Leg Pain Joint Pain (if so, where?): _____

26. **Neurologic** (please circle any that you experience now and underline any that you have experienced in the past):

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

27. **Endocrine** (please circle any that you experience now and underline any that you have experienced in the past):

Hypothyroid Hypoglycemia Hyperthyroid Diabetes Mellitus Night Sweats Feeling Hot or Cold

28. **Other** (please circle any that you experience now and underline any that you have experienced in the past):

Anemia Cancer Rashes Eczema/Hives Cold Hands/Feet

Is there anything else we should know? _____

29. **Lifestyle:**

a. Do you typically eat at least three meals per day? Y N If no, how many? _____
b. Exercise routine: _____
c. Spiritual practice: _____
d. How many hours per night do you sleep? _____ Do you wake rested? Y N
e. Level of education completed: High School Bachelors Masters Doctorate Other

- f. Occupation: _____ Employer: _____ Hours/Week: _____
Do you enjoy work? Y/N Why/Why not? _____
- g. Nicotine/Alcohol/Caffeine/ recreational drug Use:

- h. Have you experienced any major traumas? Y N Explain: _____

- i. How many glasses of non-caffeinated, non-carbonated beverages do you drink per day? _____
- j. Television habits: _____ Reading habits: _____
- k. Interests and hobbies: _____

How did you hear about us? _____