Oakland Community Acupuncture

HEALTH HISTORY

Date: ____ / ____ / _____

Name:			Sex:	Age:
Address:		City:	State:	Zip Code:
Home Phone #:	Other Phone #: Work Cell Other		Email:	
Date of Birth:	Employer:		Occupation:	
Health Care Providers:	Relationship Status: Single Married Separated Divorced Widowed Living w/partner Other			
Height:	Usual Blood Pressure:			
Weight:	Weight One Year Ago:		How did you hear of our clinic?	
Are you or may you be currently pregnant?			Have you been treated by Acupuncture or Oriental medicine before? No Yes When: ____ / ____ / _____	

MAIN COMPLAINTS

Please write in your top 3 health complaints/ concerns in order of importance to you. Mark the items that make it better or worse and mark on the scale from 1-10 the severity of the condition.
(1 = no symptoms, 10 = worst ever)

1

Nature of Complaint: ____________________

For How Long? ____________________

Heat Makes it:

Cold Makes it:

Damp Weather:

Exercise/Activity:

1 —————————————— 10

2

Nature of Complaint: ____________________

For How Long? ____________________

Heat Makes it:

Cold Makes it:

Damp Weather:

Exercise/Activity:

1 —————————————— 10

3

Nature of Complaint: ____________________

For How Long? ____________________

Heat Makes it:

Cold Makes it:

Damp Weather:

Exercise/Activity:

1 —————————————— 10

HEALTH HISTORY

Check the ☐ if you have / had the condition and note the year it started.
Check the ◯ if there is a family history of the condition.

	YOU	Year	FAMILY
Cancer type(s)? ____________		_______	
Diabetes		_______	
Hepatitis		_______	
High Blood Pressure		_______	
Heart Disease		_______	
Stroke		_______	
Seizure Disorder		_______	
Thyroid Disease		_______	
Asthma		_______	
Pacemaker		_______	
Arthritis		_______	
Chronic Fatigue		_______	
Gastritis/Pancreatitis		_______	
Hypo/Hyperglycemia		_______	
Lyme Disease		_______	
Infertility		_______	
Elevated Cholesterol		_______	

	YOU	Year	FAMILY
Osteoporosis		_______	
Herpes		_______	
AIDS / HIV		_______	
Other STD		_______	
Rheumatic Fever		_______	
Alcoholism		_______	
Allergies; type(s) ____________		_______	
Mental Illness		_______	
Kidney Disease		_______	
Anemia		_______	
Chronic Pain		_______	
Diverticulitis/IBS		_______	
Emphysema		_______	
Raynaud's Disease		_______	
Venereal Disease		_______	
Addiction		_______	
Other ___________			

DIET

Low/No Carb, Vegetarian/Vegan, Portion Control, Low Fat, Standard American
Current or past eating disorder?

Typical Breakfast: ______________________________

Typical Lunch: ______________________________

Typical Dinner: ______________________________

Typical Snacks: ______________________________

HABITS

	Amount/Week	If quit, Year?
Coffee/Tea	_____________	_______
Soda	_____________	_______
Tobacco	_____________	_______
Alcohol	_____________	_______
Drugs	_____________	_______

EXERCISE

Do you exercise regularly?
If so, what types? What frequency/duration?

____

____

____

____

MEDICATIONS

Please list all Medications, Herbs, and Supplements that you take Regularly

____

____

____

____

INJURIES & TRAUMAS (PHYSICAL/EMOTIONAL)

When	What Happened?
______	______________________________
______	______________________________
______	______________________________

SURGERIES

When	What Surgery?
______	______________________________
______	______________________________
______	______________________________

CHILDHOOD HEALTH HISTORY

Allergies	Frequent Earaches	Scarlet Fever	Forceps Delivery
Asthma	Frequent Soar Throat	Premature Birth	Other Birth Trauma ____________________
Chicken Pox	Frequent Cold/Flu	Prolonged Labor	Other ____________________

MUSCULOSKELETAL/EXTREMITIES

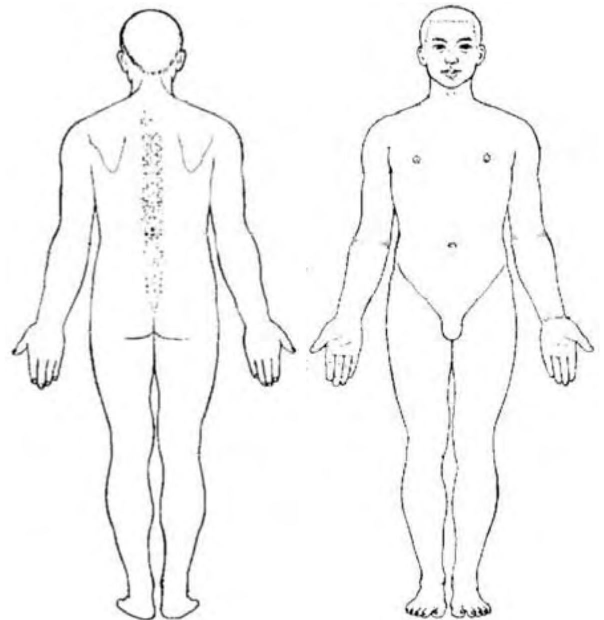
Pain, Weakness, Numbness in:

Head	Wrists	Legs
Neck	Hands	Knees
Shoulders	Fingers	Ankle
Arms	Back: U/M/L	Feet
Elbows	Hips	Toes

Joint Swelling	Edema	Carpal Tunnel
Broken Bones	Tendonitis	Sprains/Strains
Bone Deformities	Muscle Pain	Rotator Cuff
Paralysis	Bursitis	Poor Balance
Whole Body Pain	Sciatica	Restricted Movement

Other ____________________

Please Mark All Places on the Body Where You Have Any Concern →



HEAD, EYES, EARS, NOSE, THROAT

Migraines	Eye Strain	Poor Hearing	Sinus Problems	Dry Lips/Mouth
Poor Vision	Dizziness	Earaches	Sore Throats	Dry Throat
Blurry Vision	Eye Pain	Ear Ringing	Lip/Mouth Sores	Difficulty Swallowing
Night Blindness	Cataracts	Excess Ear Wax	Tongue Sores	Headaches
Glasses	Red/Itchy Eyes	Nose Bleeds	Grinding Teeth	Heavy-Headed
Spots in Eyes	Color Blindness	Poor Smell	Jaw Locks/Clicks	Light-Headed

CARDIOVASCULAR

Shortness of Breath	Irregular Heart Beats	Blood Clots	Bleed/Bruise Easily	Phlebitis
Slow Heart Rate	Palpitations	Spontaneous Sweating	Chest Pain/Pressure	High Blood Pressure
Fast Heart Rate	Varicose/Spider Veins	Fainting	Hands/Feet Swelling	Low Blood Pressure

RESPIRATORY

Cough/Wheezing	Pneumonia	Difficult Inhale/Exhale	Bronchitis
Frequent Colds	Coughing Blood	Pain on Deep Inhalation	Phlegm (color:______________)
Frequent Fevers	Asthma	Chest Tightness	Difficulty Breathing when lying down

GASTROINTESTINAL

BM: How Often? __x/__day(s)	Black Stools	Hemmorhoids	Hiatal Hernia	Dry Stools	Gas
Stools keep shape? Y/N	Bloating	Bowel Incontinence	IBS/Crohn's Disease	Difficult to Pass	Rectal Pain
Indigestion	Belching	Poor Appetite	Blood in Stool	Tired after BM	Abdominal Pain
Nausea/Vomiting	Bad Breath	Excessive Hunger	Heartburn/Reflux	Cramps w/ BM	
Peculiar Tastes/Smells	Excess Saliva	Feel a "lump in throat"	Stomachaches	Unsatisfying BM	

DIARRHEA 1 ——— 10 CONSTIPATION

GENITO-URINARY

Clear Urine	Scanty Urine	Blood in Urine	Frequent UTI	Prostate Disease	Testical Pain	Jock Itch
Dark Urine	Profuse Urine	Painful Urine	Erectile Dysfunction	Decreased Libido	Herpes	Vasectomy
Cloudy Urine	Frequent Urine	Incontinence	Difficult Start/Stop	Premature Ejaculation	Genital Pain	Hernia
Burning Urine	Urgent Urine	Kidney Stones	Fluid in = Fluid out	Nocturnal Emission	Genital Sores	Excess Libido

GYNECOLOGICAL

Vaginal Dryness	Endometriosis	Cramps	Digestive Changes w/ Period	Length of Cycle:____________ days
Vaginal Sores	Fibroids	Clots	Fibrocystic Breast Tissue	Length of Menses:__________ days
Vaginal Discharge	PMS	Breasts Tender	Polycystic Ovarian Disease	Menopause: Age ________________
Infertility	Painful Periods	Mood Changes	Difficult/Painful Intercourse	Number of Pregnancies:___________
Irregular Periods	Heavy Periods	Period Fatigue	Age at First Menses_________	Number of Births: _______________
Ovarian Cysts	Light Periods	Spotting	Date of Last Menses ________	# of Abortions/Miscarriages: ________

NEURO – PSYCHO – EMOTIONAL

Seizures	Nervousness	Bi-Polar	Angry	Concussion	Seasonal Affective Disorder
Loss of Balance	Anxiety	Poor Memory	Sad	Poor Concentration	Difficulty Expressing Emotions
Vertigo/Dizziness	Panic Attacks	Forgetful	Grief	Overthinking	Frequently Sigh / Yawn
Areas of Numbness	Irritable	ADD/ADHD	Joy	Tremors	Other ________________
Lack of Coordination	Depression	Fearful	Indecision	Easily Stressed	

ENERGY

Wired	Fatigue
Dependence on Caffeine	Body feels Heavy
Energy Drop after Eating	Body feels Weak

Sudden Energy Drop; Time of Day:________________

SLEEP

Difficulty Falling Asleep	Sleep Walk/Talk	Not Rested Upon Waking
Difficulty Staying Asleep	Disturbing Dreams	Wake _____x/night
Excessive Sleep	Wake to Urinate	Sleep: ____hrs./night
Not Enough Sleep	Restless Sleep	

SKIN - HAIR - NAILS

Rashes	Eczema	Thick Skin	Dry Nails	Hair Loss	Ulcerations
Acne	Psoriasis	Scaly Skin	Discolored Skin	Dry/Brittle Hair	Weak Nails
Dandruff	Dermatitis	Thin Skin	Dark Under Eyes	Premature Greying	Ridged Nails
Itching	Face Flushing	Thin Nails	Nail Fungus	Recent Moles	Change in Hair/Skin Texture
Warts	Hives	Dry Skin	Abscesses/Infections	Lumps	Other ____________________

TEMPERATURE

Cold Hands & Feet	Thirst for Cold Drinks	Excessive Thirst	Hot Flashes	Unusual Sweats:
Cold "in the bones"	Thirst for Hot Drinks	Hot Hands	Hot in Afternoon	Where on Body: ______________
Areas of Numbness	Thirst, No Desire to Drink	Hot Feet	Hot at Night	What time:_____ am/pm
Chills	Absence of Thirst	Hot Chest	Night Sweats	