

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
		Divorced	Widowed	Separated
			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. Circle 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 _____

Heat makes it: _____

Cold makes it: _____

Damp weather: _____

Exercise / Activity: _____

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2 Nature of complaint _____

Heat makes it: _____

Cold makes it: _____

Damp weather: _____

Exercise / Activity: _____

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3 Nature of complaint _____

Heat makes it: _____

Cold makes it: _____

Damp weather: _____

Exercise / Activity: _____

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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		YOU	Year	FAMILY
Cancer type(s)? _____					Osteoporosis		
Diabetes _____					Herpes		
Hepatitis _____					AIDS / HIV		
High Blood Pressure _____					Other STD		
Heart Disease _____					Rheumatic Fever		
Stroke _____					Alcoholism		
Seizure Disorder _____					Allergies type(s)? _____		
Thyroid Disease _____					Mental Illness		
Asthma _____					Kidney Disease		
Pacemaker _____					Anemia		
Arthritis _____					Chronic Pain		
Chronic Fatigue _____					Diverticulitis/IBS		
Gastritis/Pancreatitis _____					Emphysema		
Hypo/Hyperglycemia _____					Raynaud's Disease		
Lyme Disease _____					Venereal Disease		
Infertility _____					Addiction		
Elevated Cholesterol _____					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?

GASTROINTESTINAL

BM: How Often? ___x/___day(s)	Black Stools	Hemorrhoids	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	

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

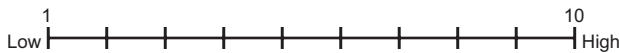
Vaginal Dryness	Endometriosis	Cramps	Digestive changes w/Period	Length of Cycle: _____ days
Vaginal Sores	Fibroids	Clots	Fibrocystic Breast Tissue	Length of Menses: _____ days
Vaginal Discharge	PMS	Breasts Tender	Polycystic Ovarian Disease	Menopause: Age _____
Infertility	Painful Periods	Mood Changes	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	

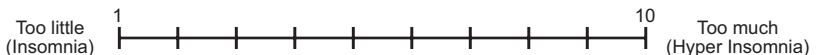
ENERGY

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	



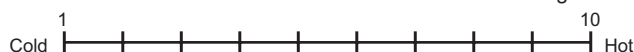
SKIN -HAIR & NAILS

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 undereyes	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 & THIRST

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	



MEDICATOINS

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

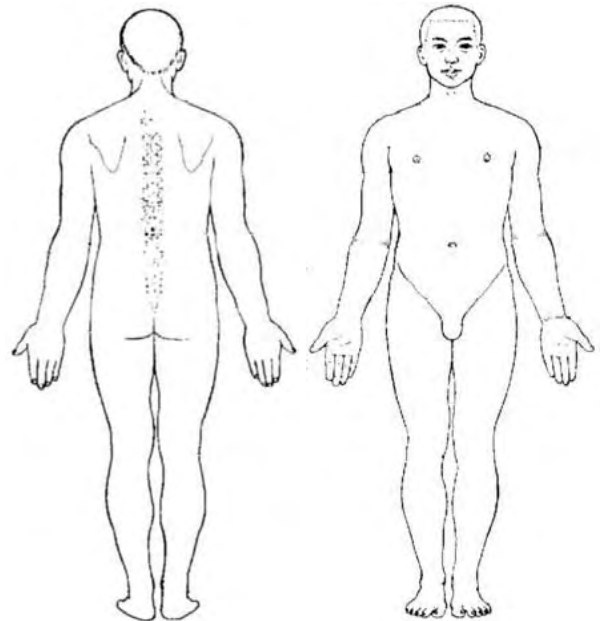
Allergies	Frequent Earaches	Scarlet Fever	Forceps Delivery
Asthema	Frequent Soar Throat	Premature Birth	Other Birth Trauma _____
Chicken Pox	Frequent Cold/Flu	Prolonged Labor	Other _____

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

Migrains	Eye Strain	Poor Hearing	Sinus Problems	Dry Lips/Mouth
Poor Vision	Dizziness	Earaches	Soar Throats	Dry Throat
Blurry Vision	Eye Pain	Ear Ringing	Lip/Mouth Soars	Difficulty Swallowing
Night Blindness	Cataracts	Excess Ear Wax	Tongue Soars	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	Cheast Pain/Pressure	High Blood Pressure
Fast Heart Rate	Varicose/Spider Veins	Fainting	Hands/Feet Swelling	Low Blood Pressure

RESPIRATORY

Cough/Wheezing	Pheumonia	Difficult Inhale/Exhale	Bronchitis
Frequent Colds	Coughing Blood	Pain on Deep Inhalation	Phelgm (color: _____)
Frequent Fevers	Asthema	Chest Tightness	Difficulty Breathing when lying down