

Petaluma 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: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Living w/partner <input type="checkbox"/> 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? <input type="radio"/> No <input type="radio"/> 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

When did this start? _____ ago

Heat makes it: better no change worse

Cold makes it: better no change worse

Damp weather: better no change worse

Exercise / Activity: better no change worse

1 |-----| 10

2

When did this start? _____ ago

Heat makes it: better no change worse

Cold makes it: better no change worse

Damp weather: better no change worse

Exercise / Activity: better no change worse

1 |-----| 10

3

When did this start? _____ ago

Heat makes it: better no change worse

Cold makes it: better no change worse

Damp weather: better no change worse

Exercise / Activity: better no change worse

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		YOU	Year	FAMILY
Cancer type(s)?	<input type="checkbox"/>	_____	<input type="radio"/>	Osteoporosis	<input type="checkbox"/>	_____	<input type="radio"/>
Diabetes	<input type="checkbox"/>	_____	<input type="radio"/>	Herpes	<input type="checkbox"/>	_____	<input type="radio"/>
Hepatitis	<input type="checkbox"/>	_____	<input type="radio"/>	AIDS / HIV	<input type="checkbox"/>	_____	<input type="radio"/>
High Blood Pressure	<input type="checkbox"/>	_____	<input type="radio"/>	Other STD	<input type="checkbox"/>	_____	<input type="radio"/>
Heart Disease	<input type="checkbox"/>	_____	<input type="radio"/>	Rheumatic Fever	<input type="checkbox"/>	_____	<input type="radio"/>
Stroke	<input type="checkbox"/>	_____	<input type="radio"/>	Alcoholism	<input type="checkbox"/>	_____	<input type="radio"/>
Seizure Disorder	<input type="checkbox"/>	_____	<input type="radio"/>	Allergies type(s)?	<input type="checkbox"/>	_____	<input type="radio"/>
Thyroid Disease	<input type="checkbox"/>	_____	<input type="radio"/>	Mental Illness	<input type="checkbox"/>	_____	<input type="radio"/>
Asthma	<input type="checkbox"/>	_____	<input type="radio"/>	Kidney Disease	<input type="checkbox"/>	_____	<input type="radio"/>
Pacemaker	<input type="checkbox"/>	_____	<input type="radio"/>	Anemia	<input type="checkbox"/>	_____	<input type="radio"/>

HABITS

	Amount / Week	If Quit, Year?
Coffee / Tea	_____	_____
Soda	_____	_____
Tobacco	_____	_____
Alcohol	_____	_____
Drugs	_____	_____

EXERCISE

Do you exercise regularly? Yes No

If so, what and how often:

DIET

Low/No Carb, Vegetarian/Vegan, Portion Control, Low Fat, Standard American

Current or past eating disorder?

MEDICATIONS

Please note what medications, herbs or supplements that you take regularly

INJURIES & SURGERIES

Please note what happened to what body area and when it occurred (incl. dental)

rrhoids
