Patient Health History Form

General Information:

How did you hear about our clinic? _____

Have you ever had acupuncture before? _____

If yes, what for, and was it helpful? _____

Patient Health Questionnaire:

What is your chief complain?

_____

_____

Duration of present condition: _____

Medications you are presently taking:

_____

_____

Medications you are allergic to: _____

Please check if you have had (in the last three months):

General

- ☐ Poor Appetite
- ☐ Fevers
- ☐ Sweats Easily
- ☐ Localized Weakness
- ☐ Change in Appetite
- ☐ Weight Loss/Gain
- ☐ Bleed or Bruise Easily
- ☐ Peculiar Tastes or Smells
- ☐ Strong Thirst (cold or hot drinks)
- ☐ Sudden Energy Drop (What time of day?)
- ☐ Cravings
- ☐ Poor sleeping
- ☐ Chills
- ☐ Tremor
- ☐ Poor Balance
- ☐ Fatigue

Skin and Hair

- ☐ Rashes
- ☐ Itching
- ☐ Dandruff
- ☐ Change in skin or hair texture?
- ☐ Ulcerations
- ☐ Eczema
- ☐ Loss of hair
- ☐ Hives
- ☐ Pimples
- ☐ Recent moles

Cardiovascular

- ☐ High Blood Pressure
- ☐ Irregular Heartbeat
- ☐ Cold Hands or Feet
- ☐ Blood Clots
- ☐ Low Blood Pressure
- ☐ Dizziness
- ☐ Swelling of hands
- ☐ Phlebitis
- ☐ Chest Pain
- ☐ Fainting
- ☐ Swelling of feet
- ☐ Difficulty Breathing

Any other heart or blood vessels problems? _____

_____