ACUPUNCTURE PLUS

Health History Questionnaire

Information for your Acupuncturist

Important: Complete this document as thoroughly as possible. Some of the questions that follow may seem unrelated to your condition, but they may play a major role in diagnosis and treatment.

All information is strictly confidential

Your General Information (Please print)

Date:_____/_____/_____Name: _____

Address: _____City: _____

State:_____ Zip code:_____ Cell Phone :(_____)_____-_____ ☐ SMS Reminder Consent

Home Phone :(_____)_____-_____ Work Phone :(_____)_____-_____

Email:_____Allow us e-mail contact ☐ Yes ☐ No

Age:_____Date of Birth_____/_____/_____Place of Birth_____

Occupation_____Guardian (if under 18):_____

Gender: ☐ Male ☐ Female Height: _____' _____" Weight: _____1bs.

Insurance Name: _____ Provider Phone #: _____

ID#: _____ Group #: _____

Does anything limit you from care? ☐ Yes ☐ No If yes, reason/s why: _____

_____

Have you done acupuncture before? Yes No (If yes, about how many times:_____)

How did you hear about our office? Referral by: _____

☐ Google ☐ Facebook ☐ Yelp ☐ Other: _____

Your purpose and goal for visiting me today:

1. _____

2. _____

3. _____

Conditions you want to improve

	Severe	Moderate	Slight	
1	☐	☐	☐	
2	☐	☐	☐	
3	☐	☐	☐	
4	☐	☐	☐	
5	☐	☐	☐	
6	☐	☐	☐	
7	☐	☐	☐	

Other conditions you want to improve:_____

How do these conditions impair your daily activities? _____

_____

Other physicians or therapists you are seeing:

Dr._____For _____

Dr._____For _____

Dr._____For _____

Medications you are taking:

Medications:_____Prescribed by_____For: _____

Medications:_____Prescribed by_____For: _____

Medications:_____Prescribed by_____For: _____

Medications:_____Prescribed by_____For: _____

Medications:_____Prescribed by_____For: _____

Supplements (if any vitamins, herbs, minerals, etc.):

_____

_____

Please check the following that pertain to you:

Energy level:	☐ High	☐ Medium	☐ Low	
Appetite:	☐ High	☐ Normal	☐ Low	
Stress level:	☐ High	☐ Medium	☐ Low	
Sleep:	☐ Good	☐ OK	☐ Poor	
Bowel Movement:	☐ Normal	☐ Loose	☐ Diarrhea	☐ Constipation
Emotion:	☐ Anxiety	☐ Anger	☐ Fear	☐ Sadness
	☐ Worry	☐ Other:_____		

Urination: Frequency_____Color_____Other _____

Recent tests: (Please indicate test results and date below)

☐Physical ☐Cholesterol ☐Prostate ☐Blood (which?) ☐HIV/STD
☐Pap Smear ☐Mammography ☐Other:_____

Your Medical History

How was your childhood health?_____

Hospital Visits / Stays: _____

Check any conditions you have had in the past:

☐Diabetes	☐Allergies	☐Glaucoma	☐Rheumatic Fever
☐Polio	☐Stroke	☐Vein Condition	☐Thyroid Disorder
☐Asthma	☐Pneumonia	☐Tuberculosis	☐Emphysema
☐Jaundice	☐Gonorrhea	☐Meningitis	☐Bleeding Tendency
☐Syphilis	☐Measles	☐Chicken Pox	☐Nervous Disorder
☐Epilepsy	☐HIV	☐Heart Disease	☐Mononucleosis
☐Paralysis	☐Cancer	☐Migraines	☐High Blood Pressure
☐Mumps	☐High Fever	☐Hepatitis	☐Multiple Sclerosis
☐Other heart illnesses		☐Other liver illnesses	☐Other kidney illnesses
☐Other spleen illnesses		☐Other lung illnesses	☐Other stomach illnesses

Other:_____

Immunization:_____

Surgeries:_____

_____

_____

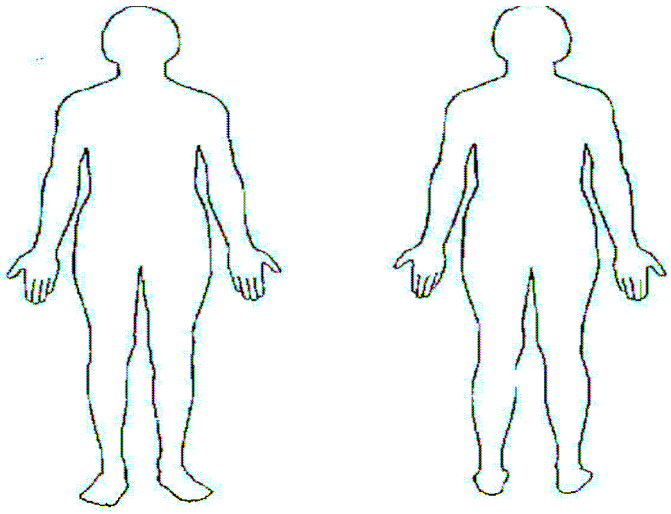
Your Family History

Family member	*Alive*	*Deceased*	*Present Health or Cause of Death*
Father	☐	☐	_____
Mother	☐	☐	_____
Spouse	☐	☐	_____
Children	☐	☐	_____
Brother	☐	☐	_____
Brother	☐	☐	_____
Sister	☐	☐	_____
Sister	☐	☐	_____

Where are you in the birth order? First Middle Last Only Other: _____

Patient Profile

Please clearly mark any areas of pain or scars: (Mark an X for *pain* or mark an O for *scars*):



Is the pain: Sharp Burning Aching Cramping Dull Moving Fixed Other: _____

Do the following lessen the pain: Pressure Cold Heat Exercise Other: _____

Do the following worsen the pain: Pressure Cold Heat Other: _____

Women's Health *(Gentleman, please go to the bottom of the page and sign it.)*

Pregnant: ☐ Yes ☐ No

Age of first menstruation:____/ Number of days of flow____

Cycle: every_____days / Vaginal discharge_____

Fertility challenge:_____

Irregular Period_____Fibroids_____

Endometriosis_____Ovarian cysts_____

Others_____

Number of pregnancies____Number of Birth____Miscarriage____

Any of the following pre-menstrual syndromes:

☐ Vomiting	☐ Nausea	☐ Headaches
☐ Anxiety	☐ Food cravings	☐ Irritability
☐ Breast swelling	☐ Depression	☐ Water retention
☐ Breast tenderness	☐ Migraines	

Please fill in the following menstrual chart:

	Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7
Color (normal, bright red, pale, brown, rust, dark, purple, other)							
Amount of flow (normal, heavy, light)							
Pain / cramps (location, dull, sharp, other)							
Clots (large, small, black, purple, red, other)							
Other							

Age of Menopause (if applicable_____Hot flashes____

Night sweats_____Dry skin_____Other_____

X_____ **Date:** **/ /**

Patient signature

Dear Patient, Please fill and sign this form.
Thank you!

Acupuncture Plus

Notification Form Regarding Evaluation of Patient by a Physician

(Pursuant to the requirement of Section 6.11, Subsection (b) through (d) V.A.C.S., article 4495b, governing the practice of acupuncture)

I _____ am notifying Acupuncture Plus of the following:

☐ Yes ☐ No I have been evaluated by a physician, dentist, or nurse practitioner for the condition being treated within six months before the acupuncture was performed.

I recognize I should be evaluated by a physician for the condition being treated by the acupuncturist.

OR

☐ Yes ☐ No I have received a referral from a chiropractor within the last 30 days for acupuncture. After being referred by a chiropractor, if after 30 days or 20 treatments, whichever comes first, no substantial improvement occurs in the condition being treated, I understand that the acupuncturist is required to refer me to a physician.

It is my responsibility and choice to follow this advice.

X _____ **Date:** ____ / ____ / ____

Patient signature

Acupuncture Plus is not responsible for untrue statements made by patients.