



# Asheville Community Acupuncture

## Health History Questionnaire and Registration

PATIENT INFORMATION	CONTACT INFORMATION
Date _____ Name _____ Address _____ City State Zip _____ Age _____ Birthdate _____ Occupation _____ Primary physician _____ How did you hear about us? _____	Home phone _____ Work phone _____ Other/cell phone _____ Email _____ Another person we may contact if needed: Name _____ Relationship _____ Home phone _____ Work/cell phone _____
HEALTH HISTORY	
What are your health goals / primary concerns that bring you in for treatment? 1 - _____ 2 - _____ 3 - _____ How is your sleep? _____ How is your digestion? _____ List medications or food supplements you are taking: _____ _____ _____ List serious illnesses, accidents or surgeries: _____ _____ Check illnesses that have occurred in blood relatives: <input type="checkbox"/> Diabetes <input type="checkbox"/> High blood pressure <input type="checkbox"/> Stroke <input type="checkbox"/> Cancer <input type="checkbox"/> Heart disease <input type="checkbox"/> Kidney disease	Check symptoms you have or have had in the last year: <input type="checkbox"/> Depression <input type="checkbox"/> Difficulty in focusing <input type="checkbox"/> Dizziness <input type="checkbox"/> Easily startled <input type="checkbox"/> Excessive worry <input type="checkbox"/> Excessive anger <input type="checkbox"/> Excessive fear <input type="checkbox"/> Fatigue/tiredness <input type="checkbox"/> Headaches <input type="checkbox"/> Loss of sleep/poor sleep <input type="checkbox"/> Loss or gain of weight <input type="checkbox"/> Nervousness/irritability <input type="checkbox"/> Overwhelmed by life  Check conditions you have or have had in the past: <input type="checkbox"/> AIDS <input type="checkbox"/> Allergies <input type="checkbox"/> Anemia <input type="checkbox"/> Arthritis <input type="checkbox"/> Bleeding disorders <input type="checkbox"/> Breast lump <input type="checkbox"/> Cancer <input type="checkbox"/> Diabetes
Have you ever had acupuncture before? Yes / No Have you ever taken Chinese Herbs? Yes / No	How long has it been since you have had a complete medical exam? _____

**HEALTH HISTORY Continued...** Check symptoms you have or have had in the last year:

**MUSCLE/JOINT/BONES**

- Tremors
- Cramps
- Swollen joints

Pain, weakness, numbness in:

- Arms or Hips
- Back Legs
- Feet
- Neck
- Hands
- Shoulders
- Other \_\_\_\_\_

**EYES/EAR/NOSE/THROAT/RESPIRATORY**

- Asthma/wheezing
- Blurred or failing vision
- Difficulty breathing
- Earache
- Enlarged glands
- Eye pain
- Frequent colds
- Hay fever
- Hoarseness
- Gum trouble
- Nose bleeds
- Loss of hearing
- Persistent cough
- Ringing in ears
- Sinus problems

**SKIN**

- Boils
- Bruise easily
- Dry skin
- Itching/rash
- Sensitive skin
- Sore won't heal
- Sweats

**FOR MEN ONLY**

- Erection difficulties
- Penis discharge
- Prostate trouble

**GENITO/URINARY**

- Blood/pus in urine
- Frequent urination
- Inability to control urine
- Kidney infection/stones
- Lowered libido

**CARDIOVASCULAR**

- Chest pain
- Hardening of arteries
- High or low blood pressure
- Pain over heart
- Poor circulation
- Previous heart attack
- Rapid/irregular heart beat
- Swelling of ankles

**GASTROINTESTINAL**

- Belching, gas or bloating
- Colon trouble
- Constipation
- Diarrhea
- Difficulty swallowing
- Distention of abdomen
- Excessive hunger
- Gall bladder trouble
- Hemorrhoids (piles)
- Indigestion
- Nausea
- Pain over stomach
- Poor appetite
- Vomiting

**FOR WOMEN ONLY**

- Bleeding between periods
  - Clots in menses
  - Excessive menstrual flow
  - Extreme menstrual pain
  - Irregular cycle
  - Menopausal symptoms
  - PMS
  - Previous miscarriage
  - Scanty menstrual flow
- Could you be pregnant? \_\_\_\_\_

**SIGNATURE**

The information on this form is correct to the best of my knowledge.

Signature \_\_\_\_\_ Date \_\_\_\_\_