SHIU
HEALING TOUCH
ACUPUNCTURE
"Leader In Health And Natural Medicine"

Health History Form

Please complete this questionnaire as thoroughly as possible. Successful healthcare and preventative medicine are only possible when the practitioner has a complete understanding of the patient's physical, mental, and emotional states. Print all information and indicate areas of confusion with a question mark. All of your answers are completely confidential. Thank you.

Name: _____ Date: _____/_____/_____
First Middle Last

Address: _____ City: _____ State: _____ Zip: _____

E-mail: _____ May we contact you via e-mail?

Cell Phone: _____ Home Phone: _____ Work Phone: _____

May we contact you by phone and leave a message if necessary? If yes, at which phone number? _____

Date of Birth: _____/_____/_____ Age: _____ Gender: _____ Marital Status: _____ Height: _____ Weight: _____

Emergency Contact: _____
Name Relationship Telephone

Occupation: _____ Hours of work per week: _____

Do you enjoy your work? Why or why not? _____

Have you received acupuncture before? If so, when and with whom? _____

Who can we thank for referring you? _____

Please identify the health concerns for which you are seeking treatment in order of importance below:

Condition	**Past Treatment**	**Date Began**
a. _____	_____	_____
How does this condition affect you? _____		
b. _____	_____	_____
How does this condition affect you? _____		
c. . _____	_____	_____
How does this condition affect you? _____		
d. . _____	_____	_____
How does this condition affect you? _____		

Please list any foods, drugs, or medications you are hypersensitive or allergic to, including your reaction:

_____

_____

_____

Please list all medications (prescribed or over-the-counter), vitamins, or supplements you are currently taking. (continue on the bottom of the last page, if necessary):

Medication	Dosage	Condition	How long?	Prescribed by

Do you have any reason to believe you may be pregnant? If so, how far along are you? _____

Do you have any infectious diseases? If yes, please identify: _____

Have you been diagnosed with a skin infection caused by staph? Was it diagnosed as MRSA?

If yes, please explain in more detail when it occurred and treatment:_____

Please list any hospitalizations and surgeries:

Reason	When	Reason	When
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Family History: Please check (✓) those applicable and indicate year of diagnosis.

	You	Father	Mother	Brothers	Sisters
Arthritis					
Asthma					
Cancer					
Diabetes					
Hay fever/Hives					
Heart Disease					
Hepatitis					
High Blood Pressure					
Kidney Disease					
Mental Illness					
Seizures/Epilepsy					
Stroke					
Tuberculosis					
Cholesterol					

Childhood Illness: __Chicken Pox __Diphtheria __German Measles __Measles __Mumps __Rheumatic Fever __Scarlet Fever Other: _____ Did you receive childhood immunizations?

Sexually Transmitted Infections: __Chlamydia __Gonorrhea __Herpes __HIV __HPV __Syphilis __Other If yes, please explain date occurred and treatment received:_____

Please indicate which of the following symptoms you experience. Click the right column for the symptoms you experience occasionally and click the left column for the ones you experience frequently.

__ __ Belching/burping
__ __ Bloating
__ __ Blood in stools
__ __ Craving sweets
__ __ Diarrhea/loose stools
__ __ Easy bruising or bleeding
__ __ Edema
__ __ Excessive appetite
__ __ Feel full quickly
__ __ Feeling of food retained in stomach
__ __ Foggy brain
__ __ Heartburn/acid reflux
__ __ Heaviness in limbs
__ __ Lack of appetite
__ __ Mucus in stools
__ __ Nausea
__ __ Obsessive or overthinking
__ __ Tarry stools
__ __ Tendency to gain weight
__ __ Tired after eating
__ __ Vomiting

__ __ Angina pains
__ __ Easily startled
__ __ Heart palpitations
__ __ Insomnia/difficulty sleeping
__ __ Lack of joy in life
__ __ Laughing for no apparent reason
__ __ Mentally restless
__ __ Nightmares/vivid dreams
__ __ Sensation of heat in the chest

__ __ Acne
__ __ Allergies
__ __ Asthma
__ __ Bronchitis
__ __ Colitis/diverticulitis
__ __ Cough
__ __ Coughing up phlegm
__ __ Dry mouth, nose, throat
__ __ Frequent colds/flu
__ __ Grief/sadness
__ __ Hemorrhoids
__ __ Hives
__ __ IBS/Crohn's Disease
__ __ Nasal discharge
__ __ Post nasal drip
__ __ Red, itchy, painful throat
__ __ Shortness of breath
__ __ Skin rashes
__ __ Sneezing
__ __ Snoring

__ __ Blurred vision/floaters
__ __ Clench teeth at night
__ __ Difficulty digestion oily foods
__ __ Difficulty making decisions
__ __ Dizziness/lightheadedness
__ __ Easily angered/irritable
__ __ Gallstones
__ __ Jaundice
__ __ Light colored stools
__ __ Neck/back/shoulder tension/pain
__ __ Spasms or muscle twitches

__ __ Craving salty food
__ __ Dry hair/skin
__ __ Ear ringing
__ __ Excessive sex drive
__ __ Feels cold easily
__ __ Feels fearful
__ __ Feels lump in throat
__ __ Hair loss
__ __ Hearing impairment
__ __ Hot flashes
__ __ Kidney stones
__ __ Knee pain
__ __ Low back pain
__ __ Low sex drive
__ __ Night sweats
__ __ Nighttime urination
__ __ Poor memory, forgetful
__ __ Soft/brittle/nails
__ __ Urinary problems

Genito-urinary (Men)

Date of last prostate checkup: _____ PSA result: _____

Frequency of urination: Daytime _____ Nighttime _____ Urine: Clear ____ Cloudy ____Odor _____

__ Blood in urine
__ Burning on urination
__ Copious urine flow
__ Decreased libido
__ Delayed stream
__ Dribbling after urination
__ Groin pain
__ Impotence
__ Incontinence
__ Increased libido
__ Kidney stones
__ Nocturnal emission
__ Pain in testicles
__ Pain on urination
__ Premature ejaculation
__ Rectal dysfunction
__ Retention of urine
__ Scanty urine flow
__ Urgent urination
__ Urinary tract infection

Gynecological/Reproductive (Women)

Age of first menses: _____ Age of menopause: _____ Number of days between periods: _____

Number of days of flow: _____ Color of flow: _____ Clots? Color/size: _____

Average number of pads/tampons you use per day: 1st____ 2nd ____ 3rd ____ 4th ____ 5th ____ 6th ____ 7th ____

Number of pregnancies: ____ Live births: ____ Abortions: ____ Miscarriages: _____

Have you been diagnosed with any of the following:

☐ Fibroids ☐ Endometriosis ☐ Ovarian Cysts ☐ PCOS ☐ PID

Gynecological/Reproductive (Women) Continued

Please indicate if you experience the following in relation to your menses (before (B), during (D), after (A)):

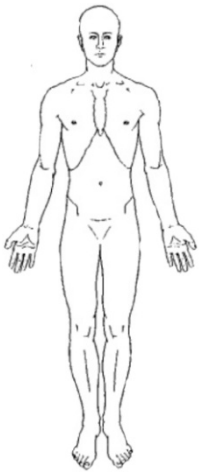
Pain: ☐ Aching ☐ Consistent ☐ Dull ☐ Sensation of bearing down
☐ Burning ☐ Cramping ☐ Intermittent ☐ Stabbing

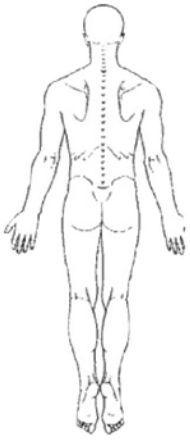
☐ Bloating	☐ Discharge	☐ Insomnia	☐ Poor appetite
☐ Constipation	☐ Headache	☐ Mood swings	☐ Ravenous appetite
☐ Decreased libido	☐ Hot flashes	☐ Nausea	☐ Swollen breasts
☐ Diarrhea	☐ Increased libido	☐ Night sweats	☐ Vaginal dryness

Musculoskeletal

☐ Back pain	☐ Hand/wrist pain	☐ Muscle pain	☐ Sciatica
☐ Bursitis	☐ Hip pain	☐ Muscle weakness	☐ Shoulder pain
☐ Carpal tunnel	☐ Knee pain	☐ Neck pain	☐ Sprains/strains
☐ Foot/ankle pain	☐ Limited range of motion	☐ Rotator cuff problems	☐ Tendonitis

Looking at the figures below, explain any injury, pain or discomfort you may be experiencing in the box below. Indicate the area of the body, the severity with a number from 1 (mild) to 10 (excruciating) and the quality; - aching, burning, numbness, pins & needles, or stabbing.





Lifestyle:

Number of meals eaten per day: _____ Number and types of snacks eaten per day: _____

What do you typically eat?

Breakfast: _____

Lunch: _____

Dinner: _____

What types and amounts of beverages do you drink each day? _____

_____

Do you drink at least 8 glasses of water per day? If not, how much?:_____

For the following substances please indicate type and average amount of current and/or past use (if applicable):

Caffeine: _____

Nicotine: _____

Alcohol: _____

Recreational Drugs: _____

Type(s) and amount(s) of exercise each week: _____

_____

Average hours of sleep per night: _____ Do you wake rested? Problems falling or staying asleep?

If yes, please describe: _____

Please choose your stress level_____

What are your primary sources of stress? _____

_____

Have you experienced any major traumas (i.e. abuse, major accidents, death of spouse/partner, etc.)? _____

If yes, please describe: _____

_____

_____

Is there anything else you would like us to know? _____

_____

_____

_____

_____

_____

_____

For office use only
This form was reviewed on by Patient ID#: