**Please complete this Health-History Form. You may email it back to the clinic (**[**bcacup@gmail.com**](mailto:bcacup@gmail.com)**) or print it out and bring it with you to your appointment. Thank You.**

**Health-History Form**

Name: Click or tap here to enter text. Date: Click or tap to enter a date.

Address: Click or tap here to enter text. City/State/Zip: Click or tap here to enter text.

Phone (day): Click or tap here to enter text. (evening): Click or tap here to enter text.

Email: Click or tap here to enter text. Date of Birth: Click or tap here to enter text.

Occupation: Click or tap here to enter text.

Emergency Contact (name and phone): Click or tap here to enter text.

Please complete this questionnaire as thoroughly as possible. All of your answers will be held in confidence within lawful limits. Print all information and indicate areas of confusion with a question mark. Please leave the right-hand columns blank. Thank you.

Please list the conditions you wish to be treated:

1) Click or tap here to enter text.

2) Click or tap here to enter text.

3) Click here to enter text.

4) Click here to enter text.

5) Click here to enter text.

Please list any medications (prescribed and over-the-counter), herbs, vitamins, and supplements you are currently taking:

|  |  |  |
| --- | --- | --- |
| **Name** | **Dosage/Amount** | **Purpose** |
| Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. |
| Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. |
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| Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. |

**Current Health (check any that apply):**

Please leave blank for acupuncturist’s notes

Click or tap here to enter text.

**Temperature**: Fever  Chills  Night sweats  Spontaneous Sweats  Hot Flashes

Do you tend to feel: Warmer than others  Cooler than others

**Thirst**: Do you tend to be thirsty? Yes  No

**Temperature drinks you prefer:** warm  room temperature  cool  cold / iced

**Digestion:** Changes in Appetite  Nausea  Vomiting  Abdominal Pain  Gas  Heartburn  Belching  Other Click or tap here to enter text.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Bowel movements**: Frequency: times per day: Choose an item. times per week Choose an item.

Formed  Loose  Liquid (diarrhea)  Difficult to pass  Incomplete

**Urination**: Color: Dark yellow  Light yellow  Clear

Amount: Scanty  Copious

Urgent  Frequent  Painful  Night-time

**Breathing:** Cough  Wheezing  Shortness of Breath Painful  Other Click or tap here to enter text.

**Head, Eye, Ear, Nose, and Throat**:

Headaches: Location: Frontal  Sides  Back  Top

Quality: dull and nagging  Intense  Sharp

Eyes: Pain/Strain  Tearing  Dryness

Ears: Ringing  Earaches

Sinus Congestion  Nose Bleeds  Frequent Sore Throats

TMJ/Jaw Problems  Other Click or tap here to enter text.

Please leave blank for acupuncturist’s notes

**Cardiovascular:** High Blood Pressure  Cold Extremities  Palpitations  Chest Pain  Edema

Swelling of Ankles  Stroke  Heart Murmurs

Do you have a pacemaker? Yes  No  Other Click or tap here to enter text.

**Sleep:** Hours per night: Choose an item.. How long does it usually take you to fall asleep? Choose an item.

Insomnia  Constant sleepiness Frequent vivid dreams

Other Click or tap here to enter text.

**Mental State:** Irritability  Anger  Anxiety  Depression  Mood Swings  Other Click or tap here to enter text.

**Energy:** Fatigue  Hyperactivity

**Immunity**: Slow Wound Healing  Chronic Infections  Frequent colds  Allergies  Do you have reduced immunity (such as HIV/AIDS, Hepatitis C, scleroderma, or vitiligo) or are you receiving any treatments that may affect your immunity (such as chemotherapy)? Yes  No  Describe Click or tap here to enter text.

Other Click or tap here to enter text.

**Reproductive:** Erectile Dysfunction  Premature ejaculation  Lack of interest in sex  Penile Discharge  Enlarged Prostrate  Testicular Pain/Swelling

Other: Click here to enter text.

**Reproductive:** Irregular Cycles  Nipple Discharge  Heavy Flow  Vaginal Discharge (describe) Click or tap here to enter text. Breast tenderness before period  Mood fluctuations before period  Painful Periods  Bleeding Between Periods

Lack of interest in sex  Other Click or tap here to enter text.

**Menstrual/Birthing History:** Age at first Menses: Click here to enter text. Length of Cycle: Click here to enter text. # of Days of Menses: Click here to enter text. Total # of Pregnancies: Click here to enter text. Live Births: Click here to enter text. Age at Onset of Menopause: Click here to enter text.

Are you pregnant? Yes  No  If yes, where are you in your pregnancy and what is your due date? Click here to enter text.

**Neurologic**: Dizziness  Loss of Balance  Paralysis  Seizures/Epilepsy  Numbness/Tingling  Other: Click here to enter text.

**Skin:** Rashes  Hives  Acne  Eczema  Sores/Wounds  Location/Other: Click here to enter text.

**Surgeries:** 1. Click here to enter text. date: Click here to enter text.

2. Click here to enter text. date: Click here to enter text.

Please leave blank for acupuncturist’s notes

Click here to enter text.

3.Click here to enter text. date: Click here to enter text.

4. Click here to enter text. date: Click here to enter text.

Do you have any other concerns that you would like to discuss? Click here to enter text.

Have you had acupuncture before? Yes  No  Do you have any special sensitivities to needling? Describe: Click here to enter text.

For Practitioner

Pulse: Click here to enter text.

Tongue: Click here to enter text.

Observations: Click here to enter text.

1st Treatment: Click here to enter text.

Tx plan: Click here to enter text.

Practitioner Name: Click here to enter text.