**Please complete this Health-History Form. You may email it back to the clinic (****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. |
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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.