

Patient Health History Form

General Information:

How did you hear about our clinic? _____

Have you ever had acupuncture before? _____

If yes, what for, and was it helpful? _____

Patient Health Questionnaire:

What is your chief complain?

Duration of present condition: _____

Medications you are presently taking:

Medications you are allergic to: _____

Please check if you have had (in the last three months):

General

- | | | |
|---|---|--|
| <input type="checkbox"/> Poor Appetite | <input type="checkbox"/> Bleed or Bruise Easily | <input type="checkbox"/> Poor sleeping |
| <input type="checkbox"/> Fevers | <input type="checkbox"/> Peculiar Tastes or Smells | <input type="checkbox"/> Chills |
| <input type="checkbox"/> Sweats Easily | <input type="checkbox"/> Strong Thirst (cold or hot drinks) | <input type="checkbox"/> Tremor |
| <input type="checkbox"/> Localized Weakness | <input type="checkbox"/> Sudden Energy Drop (What time | <input type="checkbox"/> Poor Balance |
| <input type="checkbox"/> Change in Appetite | of day?) | <input type="checkbox"/> Fatigue |
| <input type="checkbox"/> Weight Loss/Gain | <input type="checkbox"/> Cravings | |

Skin and Hair

- | | | |
|--|---------------------------------------|---------------------------------------|
| <input type="checkbox"/> Rashes | <input type="checkbox"/> Ulcerations | <input type="checkbox"/> Hives |
| <input type="checkbox"/> Itching | <input type="checkbox"/> Eczema | <input type="checkbox"/> Pimples |
| <input type="checkbox"/> Dandruff | <input type="checkbox"/> Loss of hair | <input type="checkbox"/> Recent moles |
| <input type="checkbox"/> Change in skin or hair texture? | | |

Cardiovascular

- | | | |
|--|---|---|
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Chest Pain |
| <input type="checkbox"/> Irregular Heartbeat | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Fainting |
| <input type="checkbox"/> Cold Hands or Feet | <input type="checkbox"/> Swelling of hands | <input type="checkbox"/> Swelling of feet |
| <input type="checkbox"/> Blood Clots | <input type="checkbox"/> Phlebitis | <input type="checkbox"/> Difficulty Breathing |

Any other heart or blood vessels problems? _____
