

NEW PATIENT HEALTH HISTORY

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Please help me provide you with a complete evaluation by taking the time to fill out this questionnaire carefully. If there is anything you wish to bring to my attention which is not asked on this form, please write it in the Comments Section. I encourage you to respond to as many questions as you are comfortable with, as it will help us to together get a clear perspective on your overall health. *Some sections of this form are quite personal. All information will be held in the strictest confidence.*

Name _____ Date _____

Address _____

City _____ State _____ Zip Code _____

Phone (H) _____ (W) _____ (Mobile) _____

Email _____ @ _____ DOB _____

May I leave a message if you are unavailable? Yes ___ No ___ Referred By _____

In Case of Emergency Contact _____

Physician Name _____

Physician Phone _____ May I contact your physician? Yes ___ No ___

Physician Address _____

Insurance Company _____ Policy Number _____

Main Reason For Seeking Acupuncture _____

How long ago did this problem begin? _____

To what extent does this problem interfere with daily activities, work, sleep, sex? _____

Have you been given a diagnosis for this problem? If so, what? _____

What kinds of treatments have you tried to address this problems? _____

What helps this condition improve? (Rest, exertion, heat, cold, etc) _____

What aggravates this condition? _____

Past Medical History (Please Include Dates)

Significant Illnesses Cancer Diabetes Hepatitis High Blood Pressure VD HIV EBV
Heart Disease Rheumatic Fever Thyroid Disease Seizure Auto Immune Disease Other

Surgeries (list dates) _____

Significant Traumas (accidents, falls, etc.) _____

Do you have any scars? _____ **Where?** _____

Birth History (premature birth, health complications, forceps delivery, etc.) _____

Allergies (drugs, chemicals, foods, seasonal) _____

Family Medical History Cancer Diabetes High Blood Pressure Mental Illness Seizures
Alcoholism Heart Disease Asthma Allergies Auto Immune Disease Stroke Arthritis
Other _____

Medications taken within the last 2 months (vitamins, herbs, homeopathics, etc) _____

Have you ever had steroid injections? Cortisone? _____

Occupational Stress (physical, chemical, psychological) _____

Do you exercise regularly? _____ Describe _____

Are you on a restricted diet? _____

Please describe an average day's meals _____

Morning _____

Afternoon _____

Evening _____

Do you smoke, chew or snuff tobacco? _____ If so, how much? _____

How much tea, coffee or soda do you drink per week? _____

How much alcohol do you drink per week? _____

Do you use any medications or drugs for non-medical reasons? _____

Head, Eyes, Ears, Nose and Throat

- | | | |
|---|--|--|
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Concussions | <input type="checkbox"/> Migraines |
| <input type="checkbox"/> Glasses | <input type="checkbox"/> Eye Strain | <input type="checkbox"/> Eye Pain |
| <input type="checkbox"/> Poor Vision | <input type="checkbox"/> Night Blindness | <input type="checkbox"/> Color Blindness |
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Blurry Vision | <input type="checkbox"/> Ear Aches |
| <input type="checkbox"/> Ringing in Ears | <input type="checkbox"/> Poor Hearing | <input type="checkbox"/> Spots in front of Eyes |
| <input type="checkbox"/> Sinus Problems | <input type="checkbox"/> Nose Bleeds | <input type="checkbox"/> Recurrent Sore Throats |
| <input type="checkbox"/> Teeth Problems | <input type="checkbox"/> Jaw Clicks | <input type="checkbox"/> Bleeding Gums |
| <input type="checkbox"/> Grinding Teeth | <input type="checkbox"/> Facial Pain | <input type="checkbox"/> Sores on Lips or Tongue |
| <input type="checkbox"/> Headaches? Where in head and what time of day? _____ | | |
| <input type="checkbox"/> Any other head or neck problems? _____ | | |

Respiratory

- | | | |
|---|---|--|
| <input type="checkbox"/> Frequent Colds | <input type="checkbox"/> Cough | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Shortness of Breath |
| <input type="checkbox"/> Pain with a deep breath | <input type="checkbox"/> Tightness of Chest | <input type="checkbox"/> Wheezing |
| <input type="checkbox"/> Production of Phlegm (what color?) _____ | | |
| <input type="checkbox"/> Other Lung Problems _____ | | |

Gastrointestinal

- | | | |
|---|--|---|
| <input type="checkbox"/> Nausea | <input type="checkbox"/> Vomiting | <input type="checkbox"/> Diarrhea |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Gas | <input type="checkbox"/> Belching |
| <input type="checkbox"/> Black or Bloody Stools | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Indigestion |
| <input type="checkbox"/> Bad Breath | <input type="checkbox"/> Rectal Pain | <input type="checkbox"/> Hemorrhoids |
| <input type="checkbox"/> Abdominal Cramps | <input type="checkbox"/> Bloating After Eating | <input type="checkbox"/> History of Parasites |
| <input type="checkbox"/> Chronic Laxative Use | <input type="checkbox"/> Constant Hunger | <input type="checkbox"/> Heartburn |
| <input type="checkbox"/> Other Stomach or Intestinal Problems _____ | | |

Genito-Urinary

- | | | |
|--|---|--|
| <input type="checkbox"/> Pain with Urination | <input type="checkbox"/> Frequent Urination | <input type="checkbox"/> Blood in Urine |
| <input type="checkbox"/> Wake to Urinate | <input type="checkbox"/> Unable to Hold Urine | <input type="checkbox"/> Kidney Stones |
| <input type="checkbox"/> Genital Itching | <input type="checkbox"/> Impotency | <input type="checkbox"/> Sores on Genitals |
| <input type="checkbox"/> Low Sex Drive | <input type="checkbox"/> Prostate Problems | <input type="checkbox"/> Infertility |
| <input type="checkbox"/> Other _____ | | |

Reproductive and Gynecologic

____ Number of Pregnancies	____ Number of Births	____ Premature Births
____ Miscarriages	____ Abortions	____ Age at First Menses
____ Date of Last Menses	____ Last PAP Date	____ Age at Menopause
____ Absence of Period	____ Painful Periods	____ Irregular Periods
____ Excess Facial Hair	____ Vaginal Discharge	____ Breast Lumps
____ Vaginal Sores	____ Infertility	____ PMS
____ Endometriosis	____ Fibroids	____ Cysts
____ Other _____		

Do you practice birth control? _____ What type and for how long? _____

Have you ever taken the birth control pill or estrogen replacement therapy? _____

Are you currently sexually active? _____ With men _____ With women _____

Any complications during pregnancy or in labor? _____

Menstruation

Please describe your menstrual cycle including the following information, be specific:

How long do you bleed? _____ How heavy? _____

Cramping? Describe: Before _____ During _____ After _____

Color of blood at Beginning _____ Middle _____ End _____

Clotting size and color _____ Breast Tenderness? _____

Bloating? _____ Headaches? _____

Length of cycle (no. of days from Day 1 of bleeding to beginning of next cycle) _____

Emotional sensitivities before, during or after menstruation? _____

Have there been any notable changes in your period in the last 6-12 months? _____

Menopause, are you Peri-Menopausal? _____ Menopausal? _____ Post? _____

Describe: _____

Additional information: _____

Musculoskeletal

- Neck Pain
- Shoulder Pain
- Hand or Wrist Pain
- Back Pain
- Hip Pain
- Knee Pain
- Foot Pain
- Muscle Pain
- Muscle Weakness
- Any other joint, muscle or bone problem? _____

Neuropsychological

- Seizures
- Dizziness or Vertigo
- Loss of Balance
- Areas of Numbness
- Lack of Coordination
- Poor Memory
- Concussion
- Depression
- Anxiety
- Bad Temper
- Irritability
- Easily stressed
- Other? _____

Personal

Are you currently experiencing any significant family stress? _____

In the past year have you experienced any significant loss? Death of a loved one or pet, job loss, miscarriage, divorce or separation, etc? _____

Do you feel actively supported by your family and friends? _____

Do you live alone? _____ Do you own pets? _____

Do you consider your home life to be stressful? _____

Do you consider your work life to be stressful? _____

Please feel free to add any other information you would like to discuss _____

Thank you for taking the time and energy to help us help you.