

PINON COMMUNITY ACUPUNCTURE

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Health History Questionnaire and Registration

PATIENT INFORMATION	CONTACT INFORMATION
<p>Date _____</p> <p>Name _____</p> <p>Address _____</p> <p>City State Zip _____</p> <p>Age _____ Birthdate _____</p> <p>How did you hear about us? _____</p> <p>_____</p>	<p>Home phone _____</p> <p>Work phone _____</p> <p>Other/cell phone _____</p> <p>Email _____</p> <p>Another person we may contact if needed:</p> <p>Name _____</p> <p>Relationship _____</p> <p>Home phone _____</p> <p>Work phone _____</p>
HEALTH HISTORY	
<p>What are your primary concerns for coming in for treatment?</p> <p>1- _____</p> <p>2 - _____</p> <p>3 - _____</p> <p>How is your sleep? _____</p> <p>_____</p> <p>How is your digestion? _____</p> <p>_____</p> <p>List medications or food supplements you are taking.</p> <p>_____</p> <p>_____</p> <p>List serious illnesses, accidents or surgeries.</p> <p>_____</p> <p>_____</p> <p>Check illnesses that have occurred in blood relatives.</p> <p>☒Diabetes ☒High blood pressure ☒Stroke</p> <p>☒Cancer ☒Heart disease ☒Kidney disease</p>	<p>Check symptoms you have or have had in the last year:</p> <ul style="list-style-type: none"><input type="checkbox"/> Depression<input type="checkbox"/> Difficulty in focusing<input type="checkbox"/> Dizziness<input type="checkbox"/> Easily startled<input type="checkbox"/> Excessive worry<input type="checkbox"/> Excessive anger<input type="checkbox"/> Excessive fear<input type="checkbox"/> Fatigue/tiredness<input type="checkbox"/> Headaches<input type="checkbox"/> Loss of sleep/poor sleep<input type="checkbox"/> Loss or gain of weight<input type="checkbox"/> Nervousness/irritability<input type="checkbox"/> Overwhelmed by life <p>Check conditions you have or have had in the past:</p> <ul style="list-style-type: none"><input type="checkbox"/> AIDS<input type="checkbox"/> Allergies<input type="checkbox"/> Anemia<input type="checkbox"/> Arthritis<input type="checkbox"/> Bleeding disorders<input type="checkbox"/> Breast lump<input type="checkbox"/> Cancer<input type="checkbox"/> Diabetes <p>How long has it been since you have had a complete medical exam? _____</p>

HEALTH HISTORY...CONTINUED

Check symptoms you have or have had in the last year:

MUSCLE/JOINT/BONES

- Tremors c Cramps
- Swollen joints

Pain, weakness, numbness in:

- Arms or Hips
- Back Legs
- Feet
- Neck
- Hands
- Shoulders
- Other _____

EYES/EAR/NOSE/THROAT/RESPIRATORY

- Asthma/wheezing
- Blurred or failing vision
- Difficulty breathing
- Earache
- Enlarged glands
- Eye pain
- Frequent colds
- Hay fever
- Hoarseness
- Gum trouble
- Nose bleeds
- Loss of hearing
- Persistent cough
- Ringing in ears
- Sinus problems

SKIN

- Boils
- Bruise easily
- Dry skin
- Itching/rash
- Sensitive skin
- Sore won't heal
- Sweats

GENITO/URINARY

- Blood/pus in urine
- Frequent urination
- Inability to control urine
- Kidney infection/stones
- Lowered libido

CARDIOVASCULAR

- Chest pain
- Hardening of arteries
- High or low blood pressure
- Pain over heart
- Poor circulation
- Previous heart attack
- Rapid/irregular heart beat
- Swelling of ankles

GASTROINTESTINAL

- Belching, gas or bloating
- Colon trouble
- Constipation
- Diarrhea
- Difficulty swallowing
- Distention of abdomen
- Excessive hunger
- Gall bladder trouble
- Hemorrhoids (piles)
- Indigestion
- Nausea
- Pain over stomach
- Poor appetite
- Vomiting

FOR MEN ONLY

- Erection difficulties
- Penis discharge
- Prostate trouble

FOR WOMEN ONLY

- Bleeding between periods
- Clots in menses
- Excessive menstrual flow
- Extreme menstrual pain
- Irregular cycle
- Menopausal symptoms
- PMS
- Previous miscarriage
- Scanty menstrual flow

Could you be pregnant? _____

SIGNATURE

The information on this form is correct to the best of my knowledge.

Signature _____ Date _____