Barefoot Doctor Community Acupuncture

Health History Form

Name: ___________________ **Date**____________________

Date of birth: _____________ **Preferred Pronouns/ Gender:**

Emergency Contact: _________________

____

Reasons for today's visit: ____

____

____

Family History: (check any that apply) **Who?:**

____Cancer _________________

____Diabetes _________________

____Heart Disease _________________

____High Blood Pressure _________________

____Stroke _________________

____Mental Illness _________________

____Autoimmune Illness _________________

Other: _________________ _________________

Allergies: Are you sensitive or allergic to any foods or drugs?

Yes/ No Which? ____

Previous Surgeries ____

Accompanying Symptoms (check any that apply)

Skin:

- ☐ Acne
- ☐ Hair Loss
- ☐ Eczema
- ☐ Itching
- ☐ Psoriasis
- ☐ Other ___________

Respiratory:

___ Bronchitis

___ Asthma

___ Cough/ shortness of breath

___ Frequent Colds

___ COPD

___ Pneumonia

Mental/Emotional:

- ☐ Anxiety
- ☐ Depression
- ☐ Irritability
- ☐ Mood Swings
- ☐ Considered or Attempted Suicide?
- ☐ Grief
- ☐ Truama/ PTS

Ear/Nose/ Throat:

___ Headaches	___ Head Injury
___ Migraines	___ Dry eyes
___ Head Injury	___ Glaucoma
___ Ear Ache	___ TMJ
___ Dizziness	___ Ear ringing
___ Impaired Vision	___ Loss of smell
___ Goiter	___ Loss of Voice

Digestive:

- ☐ Nausea/ vomiting
- ☐ Loss of appetite
- ☐ Ulcer
- ☐ Gas/bloating/cramping
- ☐ Constipation
- ☐ Diarrhea/ loose stool
- ☐ Hemorrhoids

Cardiovascular:

___ Heart disease
___ chest pain
___ palpitations
___ high blood pressure
___ blood clots/ varicosity
___ cold hands/feet

Musculo-skeletal:

- ☐ Weakness
- ☐ Spasm/cramps
- ☐ Joint pain
- ☐ Fibromyalgia
- ☐ Acute injury

Lifestyle:

Dietary restrictions? Y/N

____

Caffeine per day ________

Alcohol per week ________

Exercise Y/N ____________

Sleep well? Y/N

Urinary/Reproductive:

___ frequent urination
___ incontinence
___ erectile dysfunction
___ STI: __________________
___ breast pain or lumps

___ abnormal PAP (when) _______

___ fibroids

___ endometriosis

___ pregnancy

Age at first menses ____

Length of monthly Cycle___

Lasting how long? ____

Accompanying symptoms: