Acorn Acupuncture: Health History & Contacts

Date: _____/_____/_____

Name: _____ Pronouns: _____

Legal Name (if different):_____

Address:_____

City: _____ State:_____ ZipCode:_____

Phone:_____-_____-_____ E-Mail: _____

Birthday: _____/_____/_____ Relationship Status:_____

Emergency Contact Name: _____

Emergency Contact Phone: _____-_____-_____ Relationship: _____

Primary Care Physician: _____ Phone: _____-_____-_____

Life Threatening Allergies: _____

Non-Life Threatening Allergies: _____

What concerns and/or goals motivated you to seek acupuncture/East Asian medicine treatment?

_____.

Current Health Concerns	Start Date	Known Cause/Diagnosis
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

(Use reverse if more space is needed)

If these concerns impact your daily activities (work, sleep, sex, hobbies), please explain how:

_____.

What, if any, therapies are you using for any of these concerns (including but not limited to prescription & over the counter medications, massage, ice): _____

_____.

Current Medications/Supplements	Reason for Taking	Dosage
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

(Use reverse if more space is needed)

Circle any of the following that are a regular part of your life:

Coffee/Tea	Alcohol	Stimulants (e.g. meth, cocaine, ritalin, steroids)
Soda	Marijuana	Depressants (e.g. oxycodone, heroin, benzo)
Tobacco	Sleep Aids	Dietary Restrictions (e.g. vegan, keto, gluten-free)
Exercise	Others:_____	

Surgical History (including dental)	Date
_____	_____
_____	_____
_____	_____
_____	_____

(Use reverse if more space is needed)

Trauma History (birth, physical, and/or emotional)	Date
_____	_____
_____	_____
_____	_____

(Use reverse if more space is needed)

Please CIRCLE if YOU have any of the following conditions and UNDERLINE if a genetically-related FAMILY MEMBER does:

Cancer	COPD	Psychiatric Diagnosis	Asthma	Rheumatic Fever
Diabetes	Stroke	Addiction	Seizures	STI/STD
High Blood Pressure	Heart Disease	Thyroid Disease	Hepatitis	HIV/AIDS
Blood Clotting Disorder		Pacemaker	Arthritis	Other:_____

Current Life Stressors: _____

Have you received Acupuncture before? _____ Are you comfortable with needles? _____

Whom should I thank for your referral? _____

Current Health Conditions – **Circle Severe Conditions** and Underline Mild Conditions

1. Energy/Immunity/Metabolism:

Fatigue	Easily Catch Colds	Allergies	Heat Surges
Weakness	Slow Wound Healing	Sweat Easily	Chills
Drops in Energy	Recent Weight Change	Chronic Infection	Night Sweats
Appetite Change/Loss		Sleep Difficulties	Other: _____

2. Head/Ear/Eye/Nose/Throat

Headaches/Migraines	Photosensitivity	Eye strain/pain	Ear Ringing
Dizziness/Vertigo	Ear aches	Sinus problems	Nasal congestion
Blurry Vision	Nose Bleeds	Snoring	Sleep Apnea
Floaters	Teeth Grinding/TMJ	Hoarse/sore throat	Night Blindness
Dry eyes	Excessive Tearing	Hearing loss	Clicking Jaw
Concussion/s	Mouth Sores	Prescription Lenses	Other: _____

3. Respiratory/Cardiovascular

Asthma/Wheezing	Cough (Dry)	Palpitations	Racing Heart
Varicose Veins	Shortness of Breath	Low Blood Pressure	Fainting
Chest Pain	Cough (Phlegmy)	Edema	Chest Tightness
High Blood Pressure	High Cholesterol	Blood Clots	Other: _____

4. GastroIntestinal/Digestion

Bad Breath	Nausea	Vomiting	Acid Reflux
Heartburn	Belching	Indigestion	Gas
Bloating	Diarrhea	Constipation	Hemorrhoids
Black Stools	Bloody Stools	Food in Stools	Other:_____

Typical Stool Color: _____ Typical Stool Frequency:_____

5. Skin/Hair/Nails

Rashes	Itching	Oozing lesions	Hives	Acne	Mole Changes
Eczema	Psoraisis	Easily bleeding	Easy Bruising	Dandruff	Hair Loss
Dry/Brittle Hair		Dry/Brittle Nails	Thin Nails	Thicker Nails	Other:_____

6. Neurological/Psychological

Seizures	Changes in Gait	Loss of Balance	Numbness	Muscle Spasms/tics
Tingling	Poor Memory	Musculoskeletal	Paralysis	Poor Concentration
Racing Mind	Nightmares	Sleep Disorder	Irritability	Vertigo
Coordination Changes		Panic Attacks	Anxiety	Mood Swings
Irritability	Quick Tempered	Other: _____		Counseling: _____

7. Genito/Urinary

Painful Urination	Urgent Urination	Incontinence	Frequent Urination
Kidney Stones	UTI	Night Waking Urination # Times _____	
Profuse Urination	Difficulty Urinating	Bed Wetting	Other:_____
Bloody Urine	Genital Sores		

8. Reproductive

Prostate Disease	Testicular Swelling	Changes in Sex Drive
Poor Sperm Production	Nocturnal Emissions	Erectile Dysfunction
Premature Ejaculation	Testicular/Penile Pain	Vasectomy

Irregular Periods	Abnormal Vaginal Discharge	Spotting
Breast Lumps	PMS (e.g. Breast Pain, Mood Swings)	Changes in Sex Drive
Vaginal Dryness	PCOS	Infertility
Hot Flashes	Heavy Periods	Light Periods
Painful Periods	Blood Clots in Periods	Nipple Discharge
Miscarriage	Abortion	Live Birth/s #_____

Birth Control: _____ HRT _____ Other: _____

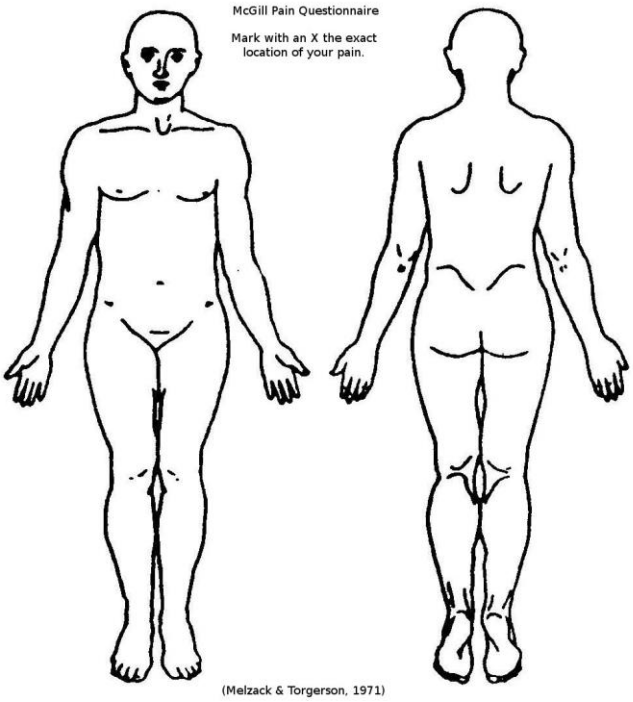
9. Musculoskeletal

Joint Pain/s (Located: _____)

Muscle Pain/s (Located: _____)

Bone Loss	Muscle Atrophy	Loss of Strength	Fractures
Arthritis	Tendonitis	Limited Range of Motion	Other: _____

Please Mark Areas of Pain with an X on the Picture Below



Areas of your life that bring you joy, resiliency, pleasure, and/or happiness:

_____.