BULL CITY ACUPUNCTURE
HEALTH HISTORY

Date: ____ / ____ / _____

Name:		Sex:	Age:
Address:	City:	State:	Zip Code:
Phone #1: Home Cell Other	Phone #2: Work Cell Other	Email:	
Date of Birth:	Emergency Contact: *(name & relationship)*	Phone #:	
Height:	Weight:	Relationship Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Living w/partner ☐ Other :_____	
Occupation:	Employer:		
How did you hear of our clinic?: ☐ Word of Mouth ☐ Internet ☐ Yellow Pages ☐ Craigslist ☐ Flyer ☐ Walk / Drive by ☐ Print Ad ☐ Other :_____	Referred by:		
Physician: Phone #:	Have you been treated by Acupuncture or Oriental Medicine Before? ☐ No ☐ Yes ____/____/____		

MAIN COMPLAINTS

Please write in your top 3 health complaints / concerns in order of importance to you. Circle the items that make it better or worse and mark on the scale from 1-10 the severity of the condition (1=no symptoms, 10=worst ever)

1 _____

When did this start? _____ago
Heat makes it: better no change worse
Cold makes it: better no change worse
Damp weather: better no change worse
Exercise / Activity: better no change worse

1 ——— 10

2 _____

When did this start? _____ago
Heat makes it: better no change worse
Cold makes it: better no change worse
Damp weather: better no change worse
Exercise / Activity: better no change worse

1 ——— 10

3 _____

When did this start? _____ago
Heat makes it: better no change worse
Cold makes it: better no change worse
Damp weather: better no change worse
Exercise / Activity: better no change worse

1 ——— 10

HEALTH HISTORY

Circle the ☨ if you have / had the condition and note the year it started.
Circle the 🕎 if there is a family history of the condition.

	YOU	Year	FAMILY
Cancer *type(s)?* _____	☨	_____	🕎
Diabetes	☨	_____	🕎
Hepatitis	☨	_____	🕎
High Blood Pressure	☨	_____	🕎
Heart Disease	☨	_____	🕎
Stroke	☨	_____	🕎
Seizure Disorder	☨	_____	🕎
Thyroid Disease	☨	_____	🕎
Asthma	☨	_____	🕎
Pacemaker	☨	_____	🕎
Osteoporosis	☨	_____	🕎
Herpes	☨	_____	🕎
AIDS / HIV	☨	_____	🕎
Other STD	☨	_____	🕎
Rheumatic Fever	☨	_____	🕎
Alcoholism	☨	_____	🕎
Allergies *type(s)?* _____	☨	_____	🕎
Mental Illness	☨	_____	🕎
Kidney Disease	☨	_____	🕎
Anemia	☨	_____	🕎

HABITS

	Amount / Week	If Quit, Year?
Coffee / Tea	_____	_____
Soda	_____	_____
Tobacco	_____	_____
Alcohol	_____	_____
Drugs	_____	_____

EXERCISE

Do you exercise regularly? ☐ Yes ☐ No
If so, what and how often:

_____
_____
_____

DIET

Do you have a special diet now or in the past? (vegetarian, vegan, raw, Atkins, etc.)
Describe w/ dates:

MEDICATONS

Please note what medications, herbs or supplements that you take regularly

_____
_____
_____

INJURIES & SURGERIES

Please note what happened to what body area and when it occurred (incl. dental)

_____
_____
_____