Acupuncture Health History

(All responses kept strictly confidential)

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Today's Date:		
Name:	Phone:	
Address (street/city/state/zip):		
Email:	Birth Date:	Age:
Occupation:	Height:	Weight:
Emergency Contact Name:	Relation to you:	Emergency Contact Phone:

Have you had acupuncture in the past? ☐ Y ☐ N	Referred by:
Main issue(s) for which you are seeking treatment, and length of time with each issue: 1)	
2)	
3)	
Medical diagnosis of above, if any:	
What other types of treatment have you tried?	
Please list major surgeries, illnesses, accidents, trauma:	
Allergies:	
Is it possible that you are pregnant? ☐ Y ☐ N #weeks ________	Do you wear a pacemaker? ☐ Y ☐ N
Please list medications/supplements taken in last 3 months:	

General:

average # hrs sleep: __________

daily water intake: ________ oz.

- ☐ Night sweats
- ☐ Change in appetite ☐ up ☐ down
- ☐ Weight loss
- ☐ Weight gain
- ☐ Insomnia
- ☐ Fatigue

Skin/Hair

- ☐ Rash, Hives
- ☐ Itching
- ☐ Eczema
- ☐ other:

Head/Ears/Eyes/Nose/Throat

- ☐ Headache
- ☐ Migraine
- ☐ Dizziness
- ☐ Jaw click/tension/pain (TMJ)
- ☐ Concussion(s) (# ________)
- ☐ Eye issues
- ☐ Runny nose/post nasal drip
- ☐ Sinus congestion
- ☐ Ringing in ears
- ☐ Hearing aid
- ☐ other:

Respiratory

- ☐ Cough
- ☐ Bronchitis
- ☐ Pneumonia
- ☐ Asthma
- ☐ Shortness of breath
- ☐ Phlegm
- ☐ other:

Cardio:

- ☐ Palpitations
- ☐ Chest pain
- ☐ Cold Hands/Feet
- ☐ other:

Musculoskeletal Pain

Back:

☐ low ☐ mid ☐ upper

- ☐ Neck
- ☐ Shoulder
- ☐ Hip
- ☐ Sciatica
- ☐ Hand/wrist
- ☐ Foot/ankle
- ☐ Elbow
- ☐ Knee
- ☐ overall muscle weakness

Neurological

- ☐ Seizure
- ☐ Stroke
- ☐ Tremors/Tics
- ☐ Numbness
- ☐ Poor memory
- ☐ Loss of balance
- ☐ other:

Psychological / Emotional

- ☐ Depression
- ☐ Fear
- ☐ Anxiety
- ☐ Anger
- ☐ Stress
- ☐ other:

Are you currently in treatment for emotional issues? ☐ Y ☐ N

Have been treated for emotional issues in the past? ☐ Y ☐ N

Have you ever considered or attempted suicide? ☐ Y ☐ N

Areas of your life that you find stressful:

Gastrointestinal:

- ☐ Constipation
- ☐ Diarrhea
- ☐ Abdominal cramps
- ☐ Vomit
- ☐ Acid reflux
- ☐ Nausea
- ☐ Bloating
- ☐ other:

Urogenital

- ☐ Frequent urination
- ☐ Blood in urine
- ☐ Pain upon urination
- ☐ Kidney stones
- ☐ Impotence
- ☐ Erectile dysfunction
- ☐ Low libido
- ☐ other:

Gynecological

Age first period: __________

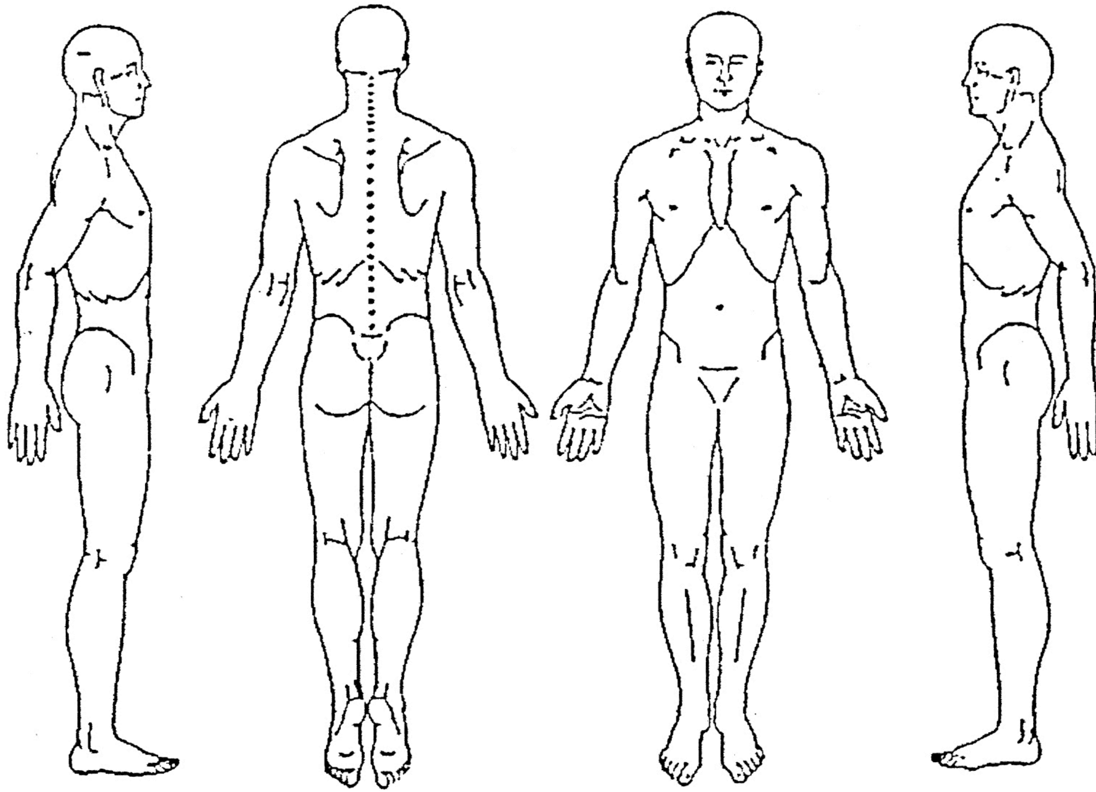
Period duration (days): __________

Period frequency (days): __________

- ☐ Irregular period
- ☐ Painful period
- ☐ Clots
- ☐ Infertility
- ☐ Pregnancy to term _____
- ☐ Miscarriage ______
- ☐ Birth Control (type: __________________)
- ☐ Fibroids
- ☐ Breast pain
- ☐ Vaginal discharge
- ☐ Cramps
- ☐ PMS
- ☐ Perimenopause
- ☐ Menopause
- ☐ other:

Exercise: please list main activities:

Please circle painful/affected areas on the diagram below:



please circle the number that best describes your **AVERAGE** pain/discomfort level:										
0 none	1	2	3	4	5 moderate	6	7	8	9	10 severe

please circle the number that best describes your **CURRENT** pain/discomfort level:										
0 none	1	2	3	4	5 moderate	6	7	8	9	10 severe

If you have or have had any of the following conditions, please indicate date of diagnosis:			
	Date Diagnosed		Date Diagnosed
☐ Cancer Type:		☐ Seizure	
☐ Diabetes Type:		☐ Stroke	
☐ STD:		☐ Hypothyroid	
☐ Hepatitis Type:		☐ Hyperthyroid	
☐ Heart Disease		☐ Fibromyalgia	
☐ High Blood Pressure		☐ Contagious Disease	
☐ High Cholesterol		☐ Other:	
☐ Heart Attack			

Informed Consent to Treatment

I hereby authorize Wellwithin to administer any style of acupuncture relevant to my diagnosis and treatment, including but not limited to the following:

- Insertion of various styles and sizes of acupuncture needles into my body at various depths and locations
- Heat treatment using Artemesia Vulgaris herb (i.e. moxibustion, “moxa”) or a conventional heat lamp
- Glass suction cupping may be used to promote circulation of Qi (energy) through the meridians. Cups may produce a circular red/purple mark on the area treated lasting for 1-5 days
- Very low voltage electrical stimulation of the needles may be used, which produces a vibration or tapping sensation. (not used if you have a pacemaker)

I have been informed that I have the right to refuse any form of treatment. I understand the nature of the treatment, have been informed of the risks and possible consequences involved with this treatment, and have been given an opportunity to ask questions pertaining to the treatment. I also understand there is always a possibility of an unexpected complication and I understand that no guarantee can be made concerning the results of treatment.

Signature of patient or legal guardian: ______________________________

Printed name of patient: ______________________________

Date: ______________________________