



Name: _____ Date: ____/____/____
(first) (middle) (last)

Date of Birth: ____/____/____ Age: ____ Gender: M / F Marital status: S M D W

Address: _____

City: _____ State: _____ Zip: _____

E-mail address: _____

Phone Number: (Best number(s) to contact you) _____

Emergency Contact - Name and Relation to you: _____

Emergency Contact - Phone Number: _____

Occupation: _____ Employer: _____

Hours per week: _____ Do you enjoy your work? Y / N

How did you find out about us? _____

Successful health care and preventative medicine are only possible when the practitioner has a complete understanding of the patient physically, mentally and emotionally. Please complete this questionnaire as thoroughly as possible. Print all information and indicate areas of confusion with a question mark. Thank you.

1. Name of Physician: _____

When and what was the nature of your last visit? _____

2. Have you ever tried acupuncture before? Y / N

3. Please let us know what conditions have brought you to receive acupuncture, in order of importance to you: (example: Condition - Back pain Past Treatment - Chiropractor, Massage How the condition affects you - discomfort, poor sleep

Condition

Past Treatment

a. _____

How does this condition affect you? _____

b. _____

How does this condition affect you? _____

c. _____

How does this condition affect you? _____

Have you experienced any major traumas? Y / N

Please explain: _____

4. If applicable, please list any foods, drugs, or medications you are hypersensitive or allergic to (please include reaction):

5. Do you have any known allergies to metals? Y / N

6. Do you have any infectious diseases? Y / N If yes, please identify: _____

When were you diagnosed? _____ Are you actively being treated? Y / N

7. Please list any medications (prescribed and over-the-counter), vitamins, and supplements you are currently taking:

8. **Family History:** Check those applicable:

	<u>Father</u>	<u>Mother</u>	<u>Brothers</u>	<u>Sisters</u>	<u>Spouse</u>	<u>Children</u>
Age (if living)	_____	_____	_____	_____	_____	_____
Health (G=Good, P=Poor)	_____	_____	_____	_____	_____	_____
Cancer	_____	_____	_____	_____	_____	_____
Diabetes	_____	_____	_____	_____	_____	_____
Heart Disease	_____	_____	_____	_____	_____	_____
High Blood Pressure	_____	_____	_____	_____	_____	_____
Stroke	_____	_____	_____	_____	_____	_____
Mental Illness	_____	_____	_____	_____	_____	_____
Asthma/Hay fever/Hives	_____	_____	_____	_____	_____	_____
Kidney Disease	_____	_____	_____	_____	_____	_____
Age (at death)	_____	_____	_____	_____	_____	_____
Cause of Death	_____	_____	_____	_____	_____	_____
Other	_____	_____	_____	_____	_____	_____

9. Height: _____ Weight: _____

10. **Blood Pressure:** Your most recent blood pressure reading? _____/_____

When was this reading taken? _____

11. **Immunization:** To your knowledge, were you immunized as a child? Y / N

Have you had any additional immunizations? If yes, please list them _____

12. **Childhood Illness:** (please circle any that you have had):

Scarlet Fever	Diphtheria	Rheumatic Fever	Mumps
Measles	German Measles	Chicken Pox	Other: _____

13. **Hospitalizations and Surgeries:**

<u>Reason</u>	<u>Year</u>	<u>Reason</u>	<u>Year</u>
_____	_____	_____	_____
_____	_____	_____	_____

14. **X-Rays/CAT Scans/MRI's/FMRI's/Special Studies:**

<u>Reason</u>	<u>Year</u>	<u>Reason</u>	<u>Year</u>
_____		_____	
_____		_____	
_____		_____	

15. **Emotional:** (please circle any that you experience now and underline any that you have experienced in the past):

Mood Swings Nervousness Mental Tension Anxiety Depression

Have you seen a doctor, or been treated for any of the above? Y / N

When: _____

16. **Energy and Immunity:** (please circle any that you experience now and underline any that you have experienced in the past):

Fatigue Slow Wound Healing Chronic Infections Chronic Fatigue Syndrome
Bleed easily Bruise Easily Sudden Energy drops

17. **Head, Eye, Ear, Nose, and Throat:** (please circle any that you experience now and underline any that you have experienced in the past):

Impaired Vision Eye Pain/Strain Glaucoma Glasses/Contacts Tearing/Dryness
Impaired Hearing Ear Ringing Earaches Headaches Sinus Problems
Nose Bleeds Frequent Sore Throats Teeth Grinding TMJ/Jaw Problems Hay Fever
Night Blindness Migraines Spots in front of the eyes

Other: _____

18. **Skin, Hair:** (please circle any that you experience now and underline any that you have experienced in the past):

Rashes Eczema/Hives Alopecia Psoriasis Acne Dry Scalp

Other: _____

19. **Respiratory:** (please circle any that you experience now and underline any that you have experienced in the past):

Pneumonia Frequent Common Colds Difficulty Breathing Emphysema

Persistent Cough Pleurisy Asthma Tuberculosis

Shortness of Breath Wheezing Pain with a deep breath

Other Respiratory Problems: _____

20. **Cardiovascular:** (please circle any that you experience now and underline any that you have experienced in the past):

Heart Disease Chest Pain Swelling of Ankles Swelling of Feet

Swelling of Hands High Blood Pressure Palpitations/Fluttering Stroke

Heart Murmurs Rheumatic Fever Varicose Veins Pace Maker

Other: _____

21. **Gastrointestinal:** (please circle any that you experience now and underline any that you have experienced in the past):

Ulcers Changes in Appetite Nausea/Vomiting Epigastric Pain Passing Gas

Heartburn Belching Gall Bladder Disease Liver Disease Hepatitis B or C

Hemorrhoids Abdominal Pain Diarrhea Constipation Chronic laxative use

Other: _____

22. **Genito-Urinary Tract:** (please circle any that you experience now and underline any that you have experienced in the past):

Kidney Disease Painful Urination Frequent UTI Frequent Urination

Heavy Flow Decrease in Flow Unable to hold urine Kidney Stones

Urgency to urinate Blood in Urine Frequent Urination at Night

How many times during the night do you wake to urinate? _____

Other: _____

23. **Musculoskeletal:** (please circle any that you experience now and underline any that you have experienced in the past):

Neck/Shoulder Pain Muscle Spasms/Cramps Arm Pain Upper Back Pain

Mid Back Pain Low Back Pain Leg Pain Foot Pain

Joint Pain (if so, where?): _____ Other: _____

24. **Neurological:** (please circle any that you experience now and underline any that you have experienced in the past):

Vertigo/Dizziness Paralysis Numbness/Tingling Loss of Balance

Seizures/Epilepsy Cold Hands / Feet Stroke Concussion

Other: _____

25. **Endocrine:** (please circle any that you experience now and underline any that you have experienced in the past):

Hypothyroid Hypoglycemia Hyperthyroid Diabetes Mellitus

Night Sweats Feeling Hot or Cold

26. **Sleep:** (please circle any that you experience now and underline any that you have experienced in the past):

Difficulty falling asleep Difficulty staying asleep Waking frequently

Weird or overactive dreams Nightmares Overactive mind keeping you awake

Sleep walking Sleep apnea

How long does it take you to fall asleep at night? _____

Do you wake feeling rested? Y / N

27. **Male Reproductive:** (please circle any that you experience now and underline any that you have experienced in the past):

Sexual Difficulties Prostrate Problems Prostate Cancer Testicular Pain/Swelling

Testicular Cancer Penile Discharge Impotence STD's

Low sperm count Premature Ejaculation Other: _____

28. **Female:**

Do you have any reason to believe you may be pregnant? Y / N

If so, how far along are you? _____

29. Are you currently trying to become pregnant? Y / N

If so, how long have you been trying? _____

Have you tried IVF or are thinking about the process? Y / N

30. **Female Reproductive/ Breasts:** (please circle any that you experience now and underline any that you have experienced in the past):

Irregular Cycles	Breast Lumps/Tenderness	Nipple Discharge	Heavy Flow
Vaginal Discharge	Premenstrual Problems	Bleeding Between Cycles	Clotting
Fibroids	Difficulty Conceiving	Painful Periods	Menopausal Symptoms
Cancer	Other: _____		

31. **Menstrual/ Birthing History:**

Age of First Menses: _____ Number of days of cycle: _____

Length of Cycle (# of days between each cycle): _____

of Abortions: _____ # of Pregnancies: _____ # of Live Births: _____

Were there any complications with any of the births? _____

of Miscarriages: _____

Are you taking birth control? Y / N Birth Control Type: _____

Have you had a hysterectomy? Y / N Age of Menopause _____

Did you have any difficulties with Menopause? _____

Other: _____

32. **Lifestyle:**

Do you typically eat at least three meals per day? Y / N If no, how many? _____

How many glasses of water do you drink per day? _____

Are you on a restricted diet? Y / N

If yes, what type: _____

Caffeine Use:	Daily	Weekly	Occasionally	Rarely	Never
Nicotine/Alcohol Use:	Daily	Weekly	Occasionally	Rarely	Never
Recreational Drug Use:	Daily	Weekly	Occasionally	Rarely	Never

Television habits: _____ Reading habits: _____

Computer habits: _____

Exercise routine: _____

Interests and hobbies: _____

Are you currently a student? Y / N

Level of education completed: High School Bachelors Masters Doctorate Other

33. Is there anything else we should know?

We understand that information about you and your health is personal and sensitive in nature. We are committed to protecting the privacy of this information. Each time you visit Glacier Blue Acupuncture, we create a record of the care and services you receive. We need this record to provide you with quality care and to comply with certain legal requirements.

There is a full visit fee for missed appointments without a 24 hour notice.

48 Hour advance cancellation is preferred and 24 is required.

If you are unable to keep your appointment, please notify us via email, text, or voicemail as soon as possible. As time and space is very limited, someone else may not be able to be seen if improper notice is given. We value your time, so please value ours as well.

I have thoroughly read, and completed the following health history form to the best of my ability

Signature

Date

Printed Name