**Pathways to Wellness Associates: Acupuncture: Health History**

|  |  |
| --- | --- |
| Name (first, last):  | DOB:  |
| Address (street):  | Gender: Female or Male |
| Address (town, state):  | Phone #:  |
| Email address:  | Occupation:  |
| Emergency Contact (name, number):  |
| Primary care physician: |

**Main Complaint:**

|  |
| --- |
| Main complaint:  |
| When did it start? | Severity: 1 (minimal) –------------------ 10 (high) |
| What makes it better and worse:  |

**Lifestyle:**

|  |  |
| --- | --- |
| Cups of water/day: | Caffeine/day: |
| Alcohol/day/week: | Tobacco use: |
| Diet (breakfast, lunch, dinner): |
| Exercise routine:  | Energy level 1 (low) – 10 (high):  |
| Emotions: happy, sad, anxious, shy/timid, worried, angry, irritable | Sudden Energy drop:  |
| Current medication/vitamins/supplements: |
| Injury, surgery, hospitalization:  |
| Allergies:  |

**Personal Medical History:**

|  |  |  |  |
| --- | --- | --- | --- |
| Asthma | Seizure/fainting | Cancer | Stroke |
| Heart disease | High or low blood pressure | Edema | Hepatitis |
| Thyroid disease | Sexually transmitted disease | Crohn’s | Diverticulitis |
| Ulcerative colitis | Gallbladder disease/removal | Kidney stones | Weight gain or loss |
| Psoriasis/eczema | Rheumatoid arthritis | Diabetes  | High cholesterol |

**Body temperature:**

|  |  |
| --- | --- |
| Cold ----------------neutral----------------hotCold hands and feet? | Night sweats: Hot flashes:Sweat easily: |

**Sleep:**

|  |  |  |
| --- | --- | --- |
| **# Hours/night** | **Difficulty falling asleep** | **Wake to urinate** |
|  | **Difficulty staying asleep** | **Rested in AM** |

**Headache, eyes, ears**:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Location** | **Dull** | **Throbbing** | **Sharp** | **Heavy** |
|  |  |  |  |  |
| **Migraine** | **TMJ pain** | **Dizziness** | **Vertigo** | **Poor memory** |
|  |  |  |  |  |
| **Poor vision**  | **Floaters** | **Dry /itchy eyes** | **Ringing ears** | **Cataracts** |
|  |  |  |  |  |

**Mouth and throat:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Thirst (cold or hot)** | **Dry mouth** | **Bleeding gums** | **Unusual taste** | **Sore throat** |
|  |  |  |  |  |

**Chest**:

|  |  |  |  |
| --- | --- | --- | --- |
| **Prone to colds** | **Chronic cough** | **Color of phlegm** | **Difficult breathing** |
|  |  |  |  |
| **Pneumonia** | **Bronchitis** | **Asthma**  | **COPD/Emphysema** |
|  |  |  |  |

**Digestion:**

|  |  |  |  |
| --- | --- | --- | --- |
| **Gas after meals** | **Bloating** | **Full easily** | **Indigestion**  |
|  |  |  |  |
| **Strong/low appetite** | **Acid reflux** | **Stomach pain** | **Nausea /vomit**  |
|  |  |  |  |

**Bowel movements:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **# Bowel/day** | **Formed or loose** | **Diarrhea** | **Constipation** | **Hemorrhoid** |
|  |  |  |  |  |
| **Foul smelling** | **Blood** | **Mucus** | **Irritable Bowel Syndrome** |  |
|  |  |  |  |  |

**Urination**:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Frequent** | **Incontinence** | **Dribbling** | **Wake at night** | **Color of urine** |
|  |  |  |  |  |
| **Clouded** | **Blood** | **Burning** | **Strong odor** |  |
|  |  |  |  |  |

**OB/GYN:**

|  |  |  |  |
| --- | --- | --- | --- |
| **Pregnant** | **# Live births** | **# Miscarriages** | **Irregular cycle** |
|  |  |  |  |
| **Birth control** | **Age of 1st period** | **Length of period** | **Length of cycle** *(start to start)* |
|  |  |  |  |
| **Painful periods** | **PMS symptoms** | **Headache/period** | **Fatigue/period** |
|  |  |  |  |

|  |  |  |
| --- | --- | --- |
| **Quality of blood** **(thin, thick, clots)** | **Color of blood (pale, bright, dark, brown, purple)** | **Bleeding between periods** |
|  |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Vaginal discharge** | **Yeast infection** | **Endometriosis** | **STD** |
|  |  |  |  |
| **Cyst** | **Fibroid** | **Hysterectomy** | **HPV** |
|  |  |  |  |

 **Menopause:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Age of menopause** | **Hot flash** | **Night sweat** | **Vaginal dryness** | **Osteoporosis** |
|  |  |  |  |  |

**Men reproduction:**

|  |  |  |  |
| --- | --- | --- | --- |
| **Loss of sex drive** | **Impotence** | **Prostate cancer** | **Testicular pain/swelling** |
|  |  |  |  |

**Pain**: Shade area(s) of pain:

|  |  |
| --- | --- |
| Better/worse with heat/cold  |  |
| Better/worse with movement |  |
| Better/worse with pressure  |  |



**(For the acupuncturist to complete)**

Initial Diagnosis:

Initial Treatment:

Initial Treatment Plan: