MAGGIE SHAO ACUPUNCTURE

1530 Center Rd, Ste 15, Novato, CA 94947 (415) 216-5992

Health History Questionnaire

Is this your first time having acupuncture? ☐ Yes ☐ No

Patient Information	**Contact Information**
Date _____ Name _____ Address _____ City, State, Zip _____ Age_____ Date of Birth _____ Occupation _____ Primary Physician _____ Physician Phone number _____	Home Phone _____ Mobile Phone _____ Email _____ Another person to contact if needed: Name _____ Relationship _____ Phone _____ How did you hear about us? _____

HEALTH HISTORY

What are your primary concerns coming in for treatment?

1. _____
2. _____
3. _____

How is your sleep? _____

Are you rested when you wake up? ☐ Yes ☐ No

How is your digestion? _____

_____

Are you taking any pain medication or blood thinners (including aspirin? ☐ Yes ☐ No

List any other medications of supplements you are taking:

_____

_____

_____

List serious illnesses, accidents or surgeries:

_____

_____

_____

_____

List any known allergies: _____

_____

_____

How long since your last complete medical exam?

_____

Check illnesses that blood relatives have/had?

☐ Diabetes ☐High Blood Pressure ☐ Stroke
☐ Cancer ☐ Heart Disease ☐ Kidney Disease

Check conditions you have or had in the past?

☐ Allergies	☐ Head trauma
☐ Anemia	☐ Hepatitis (type__)
☐ Arthritis	☐ HIV/AIDS
☐ Bleeding Disorder	☐Hypo/Hyper thyroid
☐ Breast lump	☐ Pacemaker
☐ Cancer	☐ Seizure
☐ Diabetes	☐ Stroke

Check symptoms you have or had in this last year.

☐ Depression
☐ Difficulty in focusing
☐ Dizziness
☐ Excessive worry or fear
☐ Excessive anger or irritability
☐ Fatigue/Tiredness
☐ Headaches or migraines
☐ Loss of sleep/poor sleep

Please continue history on next page . . .

Patient Name _____

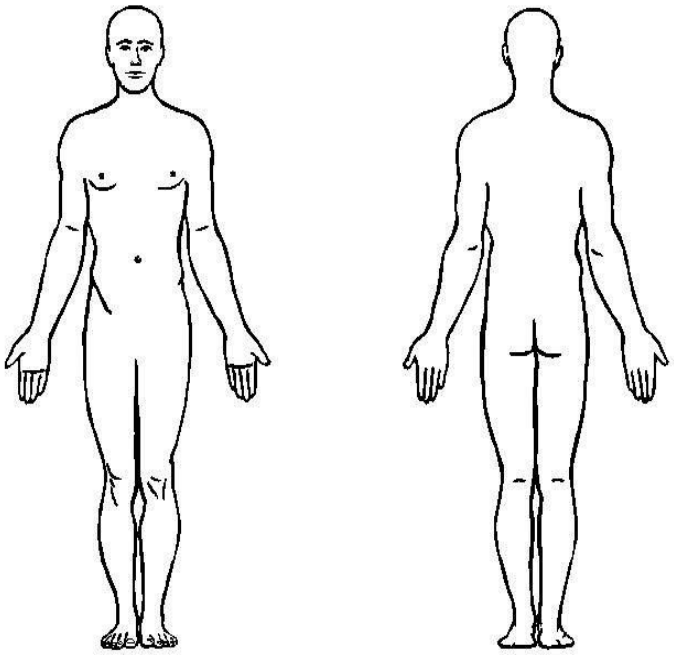
HEALTH HISTORY . . . *continued*

Check symptoms you have or had in the last year:

MUSCULOSKELETAL

☐ Tremors ☐ Muscle cramps
☐ Swollen Joints

Circle or place X on areas of pain/concern:



EYES/EAR/NOSE/THROAT/RESPIRATORY

☐ Asthma/wheezing ☐ Difficulty breathing
☐ Blurred/failing vision ☐ Eye pain
☐ Earache ☐ Enlarged glands
☐ Hay fever ☐ Frequent Colds
☐ Gum trouble ☐ Nose bleeds
☐ Loss of hearing ☐ Sinus problems
☐ Ringing in ears

GASTROINTESTINAL

☐ Belching, gas ☐ Bloating
☐ Constipation ☐ Diarrhea
☐ Excessive hunger ☐ Poor appetite
☐ Hemorrhoids ☐ Pain in abdomen
☐ Nausea ☐ Vomiting

CARDIOVASCULAR

☐ Chest Pain ☐ High Cholesterol
☐ High Blood Pressure ☐ Low Blood Pressure
☐ Previous Heart Attack ☐ Poor Circulation
☐ Rapid or irregular heartbeat

SKIN

☐ Acne/boils ☐ Bruise Easily
☐ Dry skin ☐ Itching/ Rash
☐ Sensitive skin ☐ Sores won't heal
☐ Profuse sweating

URINARY

☐ Bladder or UT infection ☐ Blood/pus in urine
☐ Frequent urination ☐ Incontinence
☐ Kidney infection/ stones

REPRODUCTIVE

Men:

☐ Lower libido ☐ Erection difficulties
☐ Penis discharge ☐ Prostate trouble
☐ Infertility

Women:

☐ Lower libido ☐ Menstrual pain
☐ Bleeding btw periods ☐ Clots in menses
☐ Excessive flow ☐ Scanty flow
☐ Irregular menstrual cycle
☐ PMS/Symptoms:_____
☐ Previous miscarriage(s) #_____
☐ Pregnancies full term #_____

Could you be pregnant now? ☐ Yes ☐ No

Any additional information not covered in questionnaire:

SIGNATURE - The information on this form is correct to the best of my knowledge

Signature _____ Date_____