

MAGGIE SHAO ACUPUNCTURE

600 Professional Center Dr, Ste 614, Novato, CA 94947 (415) 216-5992

Health History Questionnaire

Is this your first time having acupuncture? Yes No

Patient Information	Contact Information														
<p>Date _____</p> <p>Name _____</p> <p>Address _____</p> <p>City, State, Zip _____</p> <p>Age _____ Date of Birth _____</p> <p>Occupation _____</p> <p>Primary Physician _____</p> <p>Physician Phone number _____</p>	<p>Home Phone _____</p> <p>Mobile Phone _____</p> <p>Email _____</p> <p>Another person to contact if needed: Name _____ Relationship _____ Phone _____ How did you hear about us? _____</p>														
HEALTH HISTORY															
<p>What are your primary concerns coming in for treatment?</p> <p>1. _____</p> <p>2. _____</p> <p>3. _____</p> <p>How is your sleep? _____</p> <p>Are you rested when you wake up? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>How is your digestion? _____</p> <p>_____</p> <p>Are you taking any pain medication or blood thinners (including aspirin)? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>List any other medications of supplements you are taking:</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>List serious illnesses, accidents or surgeries:</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>List any known allergies: _____</p> <p>_____</p> <p>_____</p>	<p>How long since your last complete medical exam?</p> <p>_____</p> <p>Check illnesses that blood relatives have/had?</p> <p><input type="checkbox"/> Diabetes <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Stroke</p> <p><input type="checkbox"/> Cancer <input type="checkbox"/> Heart Disease <input type="checkbox"/> Kidney Disease</p> <p>Check conditions you have or had in the past?</p> <table style="width: 100%; border: none;"> <tr> <td><input type="checkbox"/> Allergies</td> <td><input type="checkbox"/> Head trauma</td> </tr> <tr> <td><input type="checkbox"/> Anemia</td> <td><input type="checkbox"/> Hepatitis (type__)</td> </tr> <tr> <td><input type="checkbox"/> Arthritis</td> <td><input type="checkbox"/> HIV/AIDS</td> </tr> <tr> <td><input type="checkbox"/> Bleeding Disorder</td> <td><input type="checkbox"/> Hypo/Hyper thyroid</td> </tr> <tr> <td><input type="checkbox"/> Breast lump</td> <td><input type="checkbox"/> Pacemaker</td> </tr> <tr> <td><input type="checkbox"/> Cancer</td> <td><input type="checkbox"/> Seizure</td> </tr> <tr> <td><input type="checkbox"/> Diabetes</td> <td><input type="checkbox"/> Stroke</td> </tr> </table> <p>Check symptoms you have or had in this last year.</p> <p><input type="checkbox"/> Depression</p> <p><input type="checkbox"/> Difficulty in focusing</p> <p><input type="checkbox"/> Dizziness</p> <p><input type="checkbox"/> Excessive worry or fear</p> <p><input type="checkbox"/> Excessive anger or irritability</p> <p><input type="checkbox"/> Fatigue/Tiredness</p> <p><input type="checkbox"/> Headaches or migraines</p> <p><input type="checkbox"/> Loss of sleep/poor sleep</p> <p style="text-align: right; margin-top: 20px;"><i>Please continue history on next page . . .</i></p>	<input type="checkbox"/> Allergies	<input type="checkbox"/> Head trauma	<input type="checkbox"/> Anemia	<input type="checkbox"/> Hepatitis (type__)	<input type="checkbox"/> Arthritis	<input type="checkbox"/> HIV/AIDS	<input type="checkbox"/> Bleeding Disorder	<input type="checkbox"/> Hypo/Hyper thyroid	<input type="checkbox"/> Breast lump	<input type="checkbox"/> Pacemaker	<input type="checkbox"/> Cancer	<input type="checkbox"/> Seizure	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Stroke
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Patient Name _____

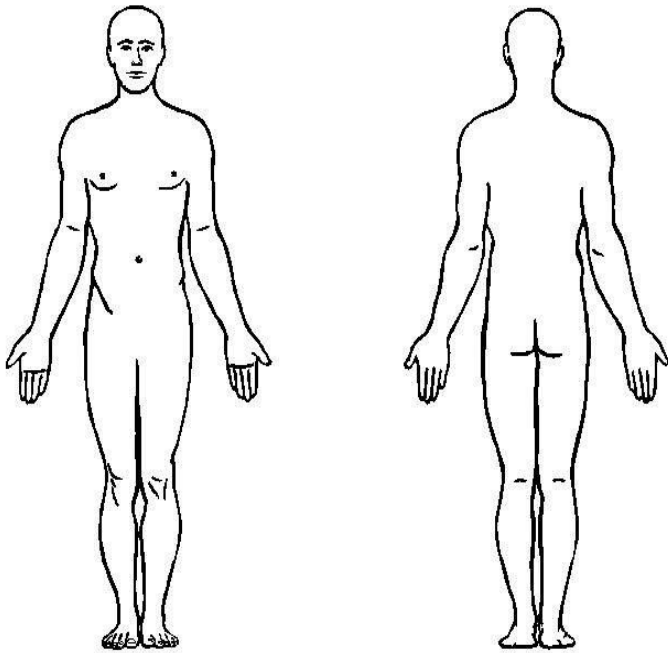
HEALTH HISTORY . . . continued

Check symptoms you have or had in the last year:

MUSCULOSKELETAL

- Tremors
- Swollen Joints
- Muscle cramps

Circle or place X on areas of pain/concern:



EYES/EAR/NOSE/THROAT/RESPIRATORY

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

GASTROINTESTINAL

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

CARDIOVASCULAR

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

SKIN

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

URINARY

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

REPRODUCTIVE

Men:

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

Women:

- Lower libido
- Bleeding btw periods
- Excessive flow
- Irregular menstrual cycle
- PMS/Symptoms: _____

- Menstrual pain
- Clots in menses
- Scanty flow
- 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 _____