Caspian Acupuncture -- Health History Form

Anita Tayyebi EAMP, LAc. 652 SW 150th St Burien WA 98166

Frist Name _____ Last: _____ Date _____

Phone (H) _____ (C)_____ (W)_____ E-mail _____

Address _____

City _____State _____ Zip _____

Age _____ DOB _____ Place of Birth _____

Marital/Partnership Status _____ Preferred Gender Pronoun _____

Profession _____

Family Physician _____Telephone # _____ Referred By _____

Emergency Contact _____Phone#_____

Have you been treated by Acupuncture or Oriental Medicine before? When and for what reason?

_____

Main Problem(s)

Are you presently being treated for a medical condition? Diagnosis?

_____

_____

Main problem(S) would you like help with? Have you been given a diagnosis for this problem? (Please be specific)

_____

_____

_____

What kind of treatment have you tried? Helped?

_____

_____

To what extent does this problem interfere with your daily activities (work, sleep, etc)?

_____

_____

Past Medical History (please include date):

Cancer _____ Diabetes _____ Hepatitis _____

Blood Pressure (High/Low) _____ /_____ Heart Disease _____

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Rheumatic Fever_____ Thyroid Disease _____ Seizures _____

STDs_____ HIV/AIDS _____

Other _____

Surgeries (type of and Date)

_____

_____

Significant Trauma (auto accidents, falls, injuries, etc)

_____

_____

Significant Dental Work (type and Date)

_____

_____

Allergies (drugs, chemicals, foods/result)

_____

_____

Occupational Stress (Physical, Chemical, Emotional, etc)

_____

_____

Family Medical History (check):

Diabetes ◯ Cancer ◯ High Blood Pressure ◯ Asthma ◯

Heart Disease ◯ Stroke ◯ Seizures ◯ Allergies ◯

Other _____

Medicines and vitamins taken within the last three months and reason for taking them

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

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Do you have a regular **exercise** program? Yes ◯ No ◯ Please Describe:
_____

Have you ever been on a restricted **diet**? Yes ◯ No ◯ What Kind? _____

_____

Height _____ Weight _____ Ideal Weight _____

Are you a **smoker**? Yes ◯ how long? _____ No ◯ Quit ◯ when? _____

If so, how many packs of cigarettes do you smoke per day? _____

How many **caffeinated** beverages (coffee, cola, energy drinks) do you drink per day? _____

How much **alcohol** do you drink per week? _____

Please describe any use of **recreational drugs**:

_____

_____

Please describe the type of foods you eat regularly:

Breakfast_____

_____

Lunch_____

_____

Dinner_____

_____

Snack/Other
Meals_____

_____

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Please check any you have had in the last three months

General

☐ Poor appetite
☐ Fevers
☐ Sweat easily
☐ Localized weakness
☐ Bleed or bruise easily
☐ Peculiar tastes or smells
☐ Strong thirst (cold or hot)
☐ No desire to drink
☐ Sudden energy drop
When? _____

☐ Poor sleep
☐ Chills
☐ Tremors
☐ Poor balance
☐ Fatigue
☐ Night sweats
☐ Cravings
☐ Change in appetite
☐ Weight gain
☐ Weight loss

Skin and Hair

☐ Rashes
☐ Itching
☐ Dandruff
☐ Change in hair or skin
☐ Ulcerations
☐ Eczema
☐ Loss of Hair
☐ Hives
☐ Pimples
☐ Recent moles
☐ Other hair or skin problems
_____

Musculoskeletal

☐ Muscle pain
☐ Muscle weakness
☐ Neck pain
☐ Shoulder pain
☐ Hand/wrist pain
☐ Back pain
☐ Hip pain
☐ Knee pain
☐ Foot/ankle pain

Head, Eyes, Ears, Throat

☐ Dizziness
☐ Poor vision
☐ Cataracts
☐ Eye strain
☐ Night blindness
☐ Blurry vision
☐ Spots in front of eyes
☐ Eye pain
☐ Color blindness
☐ Earaches
☐ Ringing in ears (tinnitus)
☐ Poor hearing
☐ Sinus problems
☐ Grinding teeth
☐ Teeth problems
☐ Jaw clicks
☐ Facial pain
☐ Nose bleeds
☐ Recurrent sore throats
☐ Sores on lips or tongue
☐ Concussions
☐ Migraines
☐ Headaches - where and when
_____
☐ Other head or neck problems
_____

Cardiovascular

☐ High blood pressure
☐ Irregular heartbeat
☐ Cold hands or feet
☐ Blood clots
☐ Low blood pressure
☐ Dizziness
☐ Swelling of hands
☐ Swelling of feet
☐ Phlebitis
☐ Chest pain
☐ Fainting
☐ Difficulty in breathing
☐ Other heart or blood vessel problems
_____

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Respiratory

☐ Cough
☐ Bronchitis
☐ Pneumonia
☐ Asthma
☐ Tuberculosis

☐ Pain with a deep breath
☐ Difficulty in breathing when lying down
☐ Production of phlegm
what color _____
☐ Coughing blood

☐ Other lung problems
_____
☐ Approximately when was your last cold or flu?
_____

Gastrointestinal

☐ Nausea
☐ Constipation
☐ Diarrhea
☐ Chronic laxative use
☐ Bad breath
☐ Belching
☐ Burning sensation

☐ Abdominal pain or cramps
☐ Vomiting
☐ Gas
☐ Indigestion
☐ Blood in stools
☐ Black stools
☐ Rectal pain

☐ Rectal burning
☐ Anal Prolapse
☐ Hemorrhoids
☐ Other stomach or intestinal problems _____

Genito-Urinary

☐ Pain on urination
☐ Urgency to urinate
☐ Frequent urination
☐ Unable to hold urine
☐ Urinary difficulty
☐ Impotency

☐ Blood in urine
☐ Kidney stones
☐ Sores on genitals
☐ Other genital or urinary system problems _____

☐ Do you wake up to urinate?
Yes ☐ No ☐
How often? _____
Any particular color to your urine?
_____

Pregnancy and Gynecology

Number of pregnancies _____
Number of births _____
Premature births _____
Miscarriages _____
Abortions _____
Age at first menses _____
Days between menses _____
Duration _____
First day of last menses
_____
☐ Unusual character of menses (heavy or light) _____

☐ Painful periods
☐ Vaginal discharge
What color? _____
☐ Changes in body/psyche prior to menstruation
☐ Clots
☐ Vaginal sores
☐ Irregular periods
☐ Last Pap _____
☐ Breast lumps

☐ Fibroid Cysts
☐ Are you sexually active? ____
Do you practice birth control?
Yes ☐ No ☐ N/A
☐ What type and for how long?
_____
☐ Other Gynecology related concerns
_____

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Neuropsychological

☐ Seizures
☐ Stroke
☐ Tremors
☐ Fainting spells
☐ Areas of numbness
☐ Concussion
☐ Poor memory
☐ Dizziness
☐Vertigo
☐ Loss of balance
☐ Lack of coordination
☐ Depression
☐ Easily stressed
☐ Bad temper
☐ Anxiety
☐ Difficulty concentrating
☐ Other neurological or psychological concerns
_____

Please note with an "X" the severity of your problem now:

I ----------I

No Problem (0/10) Worst Imaginable (10/10)

Please note with an "X" the severity of your problem within the last week:

I ----------I

No Problem (0/10) Worst Imaginable (10/10)

Indicate painful or distressed areas: