

Caspian Acupuncture -- Health History Form
Anita Tayyebi EAMP, L.Ac. Licensed in Washington State, # AC60608107

First 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 _____

Caspian Acupuncture -- Health History Form
Anita Tayyebi EAMP, L.Ac. Licensed in Washington State, # AC60608107

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

Caspian Acupuncture -- Health History Form
Anita Tayyebi EAMP, L.Ac. Licensed in Washington State, # AC60608107

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 _____

Caspian Acupuncture -- Health History Form
Anita Tayyebi EAMP, L.Ac. Licensed in Washington State, # AC60608107

Please check any you have had in the last three months

General

- | | | |
|--|---|---|
| <input type="checkbox"/> Poor appetite | <input type="checkbox"/> No desire to drink | <input type="checkbox"/> Fatigue |
| <input type="checkbox"/> Fevers | <input type="checkbox"/> Sudden energy drop | <input type="checkbox"/> Night sweats |
| <input type="checkbox"/> Sweat easily | When? _____ | <input type="checkbox"/> Cravings |
| <input type="checkbox"/> Localized weakness | | <input type="checkbox"/> Change in appetite |
| <input type="checkbox"/> Bleed or bruise easily | <input type="checkbox"/> Poor sleep | <input type="checkbox"/> Weight gain |
| <input type="checkbox"/> Peculiar tastes or smells | <input type="checkbox"/> Chills | <input type="checkbox"/> Weight loss |
| <input type="checkbox"/> Strong thirst (cold or hot) | <input type="checkbox"/> Tremors | |
| | <input type="checkbox"/> Poor balance | |

Skin and Hair

- | | | |
|---|---------------------------------------|--|
| <input type="checkbox"/> Rashes | <input type="checkbox"/> Ulcerations | <input type="checkbox"/> Pimples |
| <input type="checkbox"/> Itching | <input type="checkbox"/> Eczema | <input type="checkbox"/> Recent moles |
| <input type="checkbox"/> Dandruff | <input type="checkbox"/> Loss of Hair | <input type="checkbox"/> Other hair or skin problems |
| <input type="checkbox"/> Change in hair or skin | <input type="checkbox"/> Hives | _____ |

Musculoskeletal

- | | | |
|--|--|--|
| <input type="checkbox"/> Muscle pain | <input type="checkbox"/> Shoulder pain | <input type="checkbox"/> Hip pain |
| <input type="checkbox"/> Muscle weakness | <input type="checkbox"/> Hand/wrist pain | <input type="checkbox"/> Knee pain |
| <input type="checkbox"/> Neck pain | <input type="checkbox"/> Back pain | <input type="checkbox"/> Foot/ankle pain |

Head, Eyes, Ears, Throat

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

Cardiovascular

- | | | |
|--|--|--|
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Fainting |
| <input type="checkbox"/> Irregular heartbeat | <input type="checkbox"/> Swelling of hands | <input type="checkbox"/> Difficulty in breathing |
| <input type="checkbox"/> Cold hands or feet | <input type="checkbox"/> Swelling of feet | <input type="checkbox"/> Other heart or blood vessel |
| <input type="checkbox"/> Blood clots | <input type="checkbox"/> Phlebitis | problems |
| <input type="checkbox"/> Low blood pressure | <input type="checkbox"/> Chest pain | _____ |

Caspian Acupuncture -- Health History Form
Anita Tayyebi EAMP, L.Ac. Licensed in Washington State, # AC60608107

Respiratory

- | | | |
|---------------------------------------|--|--|
| <input type="checkbox"/> Cough | <input type="checkbox"/> Pain with a deep breath | <input type="checkbox"/> Other lung problems _____ |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Difficulty in breathing when lying down | <input type="checkbox"/> Approximately when was your last cold or flu? _____ |
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Production of phlegm what color _____ | _____ |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Coughing blood | |
| <input type="checkbox"/> Tuberculosis | | |

Gastrointestinal

- | | | |
|---|---|---|
| <input type="checkbox"/> Nausea | <input type="checkbox"/> Abdominal pain or cramps | <input type="checkbox"/> Rectal burning |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Vomiting | <input type="checkbox"/> Anal Prolapse |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Gas | <input type="checkbox"/> Hemorrhoids |
| <input type="checkbox"/> Chronic laxative use | <input type="checkbox"/> Indigestion | <input type="checkbox"/> Other stomach or intestinal problems _____ |
| <input type="checkbox"/> Bad breath | <input type="checkbox"/> Blood in stools | |
| <input type="checkbox"/> Belching | <input type="checkbox"/> Black stools | |
| <input type="checkbox"/> Burning sensation | <input type="checkbox"/> Rectal pain | |

Genito-Urinary

- | | | |
|---|---|--|
| <input type="checkbox"/> Pain on urination | <input type="checkbox"/> Blood in urine | <input type="checkbox"/> Do you wake up to urinate? Yes <input type="checkbox"/> No <input type="checkbox"/> |
| <input type="checkbox"/> Urgency to urinate | <input type="checkbox"/> Kidney stones | How often? _____ |
| <input type="checkbox"/> Frequent urination | <input type="checkbox"/> Sores on genitals | Any particular color to your urine? _____ |
| <input type="checkbox"/> Unable to hold urine | <input type="checkbox"/> Other genital or urinary system problems _____ | |
| <input type="checkbox"/> Urinary difficulty | | |
| <input type="checkbox"/> Impotency | | |

Pregnancy and Gynecology

- | | | |
|---|---|---|
| Number of pregnancies _____ | <input type="checkbox"/> Painful periods | <input type="checkbox"/> Fibroid Cysts |
| Number of births _____ | <input type="checkbox"/> Vaginal discharge | <input type="checkbox"/> Are you sexually active? _____ |
| Premature births _____ | What color? _____ | Do you practice birth control? Yes <input type="checkbox"/> No <input type="checkbox"/> N/A |
| Miscarriages _____ | <input type="checkbox"/> Changes in body/psyche prior to menstruation | <input type="checkbox"/> What type and for how long? _____ |
| Abortions _____ | <input type="checkbox"/> Clots | _____ |
| Age at first menses _____ | <input type="checkbox"/> Vaginal sores | <input type="checkbox"/> Other Gynecology related concerns _____ |
| Days between menses _____ | <input type="checkbox"/> Irregular periods | |
| Duration _____ | <input type="checkbox"/> Last Pap _____ | |
| First day of last menses _____ | <input type="checkbox"/> Breast lumps | |
| <input type="checkbox"/> Unusual character of menses (heavy or light) _____ | | |

Caspian Acupuncture -- Health History Form
Anita Tayyebi EAMP, L.Ac. Licensed in Washington State, # AC60608107

Neuropsychological

- | | | |
|--|---|--|
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Vertigo | <input type="checkbox"/> Difficulty concentrating |
| <input type="checkbox"/> Tremors | <input type="checkbox"/> Loss of balance | <input type="checkbox"/> Other neurological or
psychological concerns |
| <input type="checkbox"/> Fainting spells | <input type="checkbox"/> Lack of coordination | _____ |
| <input type="checkbox"/> Areas of numbness | <input type="checkbox"/> Depression | |
| <input type="checkbox"/> Concussion | <input type="checkbox"/> Easily stressed | |
| <input type="checkbox"/> Poor memory | <input type="checkbox"/> Bad temper | |

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:

