Premier Acupuncture

Patient Name _____ **DOB** _____ **Date** _____ **Weight** _____

THIS IS A FILLABLE PDF FORM. PLEASE COMPLETE THIS FORM ON YOUR COMPUTER, PRINT AND BRING TO YOUR FIRST APPOINTMENT. USE LOWER CASE LETTERS FOR MORE SPACE. USE A SEPERATE SHEET OF PAPER IF NEEDED.

HEALTH HISTORY

MAIN COMPLAINTS	Intensity	
In the space below, please list the reason you are here today. Please list in the order of importance. Use seperate sheet of paper if more room is required.	On a scale of "1 to 10", please rate the intensity of your chief complaint (0 = ***no discomfort,*** 10 = ***extreme discomfort***)	
	on **AVERAGE** your complaint is	at **WORST** your complaint is:
1.		
2.		
3.		
4.		
5.		
6.		

	Onset	What have you tried doing to resolve these problems that DID NOT work?
	Your best guess as to when complaints began	**Please list past and current treatments that have not worked or have had limited effect.**
1	Date began:	
2	Date began:	
3	Date began:	
4	Date began:	
5	Date began:	
6	Date began:	

	Frequency	Duration
	How often are these complaints present (Constantly, ____ days per week ___ days per month ___ Other)	When you are feeling your symptoms, how long do your symptoms last? (min, hrs, days, constant)
1		
2		
3		
4		
5		
6		

	What Aggravates or Alleviates your Chief Complaints?	
	What AGGRAVATES each of the complaints above?	What ALLEVIATES each of the complaints above?
1		
2		
3		
4		
5		
6		

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How are your health problems interfering with the following areas of your life?	
Work	
Family	
Hobbies	
Life	

How have you taken care of these complaints in the past?

- ☐ Medications
- ☐ Surgery
- ☐ Injections
- ☐ Exercise
- ☐ Dietary Modifications
- ☐ Vitamins & Supplements
- ☐ Acupuncture
- ☐ Herbal Medicine
- ☐ Chiropractic
- ☐ Massage
- ☐ Other: _____

How did the previous methods work for you?

_____

What do you desire from treatment? (choose one)

- ☐ Just want relief from symptoms then will see what happens
- ☐ Want to correct the cause of the problem and start a program directed at addressing these causes

Other: _____

If we were to sit down and discuss your life 2 years from now and look back at today, what would have to have happened for you to be happy with your progress during our time addressing your health concerns? ie. able to engage in activities you love, off pain meds, etc.

_____

What potential barriers do you foresee that would prevent you from achieving your health goals?

_____

Do you feel it is possible to eliminate or reduce these barriers to achieving your goals?

_____

Rate on a scale of 1-10 *(1 being lowest, 10 being highest):*

How important is it for you to resolve your health concerns? _____

Are you prepared to make the necessary changes to achieve your goals? _____

ARE YOU PREGNANT? ☐ Yes ☐ No If yes, what is your due date _____

How much exercise do you get? _____

Do you smoke? ☐ Yes ☐ No How much water do you drink? _____ Do you drink soda? ☐ Yes ☐ No

Do your work activities mostly involve: ☐ Sitting ☐ Light Labor ☐ Heavy Labor

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If the following imaging methods are relevent to your currunt compaint(s) please complete. Otherwise you can skip this part.

IMAGING & TESTS	DATES	RESULTS
X-ray		
MRI's		
CT Scan		
Mammogram		
Ultrasound		

Please list all health care providers (family physicians, surgeons, specialists, chiropractors, etc.) currently treating you:

List all medical conditions you are currently being treated for (include the dates of when you were diagnosed if known, approximate if needed):

List all types of surgeries you have had in the past (include dates if known month and year, approximate if needed):

List all significant accidents you have had in the past (include dates if known - month and year, approximate if needed):

List all Allergies (food, medications, pollen, etc.):

List all Medications (prescription & over-the-counter) you are currently taking (include dosage if known):

List all nutritional supplements, herbs, or vitamins you are currently taking:

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The bottom section of this page is a fillable PDF, the image section is not. In order to complete the image section found below, you will need to print and complete manually.

If you are being seen for a pain related problem, or if you are experiencing pain but being seen for a non-pain related problem, please provide the requested information below.

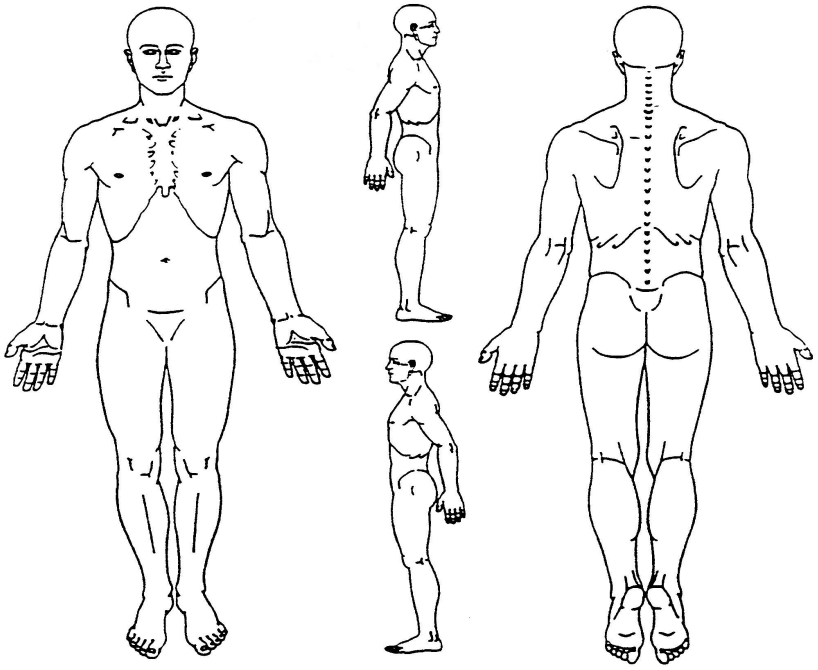
Please Show Areas Of:

Primary Pain using - ***

Secondary Pain using - 0

Numbness using - ////

Pins and needles using - P



If there is any additional information you think would be helpful that has not been asked previously, please include it below. You can complete this section online - the section below is a fillable PDF.

Patient Name _____ **DOB** _____ **Date** _____

Please check all symptoms you experience. These questions may not seem to be related to your current complaint, but they will aid in evaluating your health and in looking for contributing factors to your current health concerns.

- ☐ Shortness of breath / wheezing / difficulty breathing
- ☐ Easily catch colds / chronic infections
- ☐ Sinus problems
- ☐ Nose bleeds
- ☐ Cough
- ☐ Snoring loss of smell / taste
- ☐ Dry nose / mouth dry
- ☐ Dry skin
- ☐ Allergies
- ☐ Alternating fever & chills
- ☐ Excessive sweating
- ☐ Difficult sweating
- ☐ Headaches
- ☐ Chronic sadness
- ☐ Constipation / hemorrhoids
- ☐ Alternating diarrhea & constipation
- ☐ Sores on tip of tongue
- ☐ Trouble falling / staying asleep
- ☐ Waking up unrefreshed, tired
- ☐ Blood or mucus in stools
- ☐ Undigested food in stool
- ☐ Diarrhea / constipation
- ☐ Bloating, excess flatulence
- ☐ Acid Regurgitation / sore throat
- ☐ Bad breath
- ☐ Sores in mouth
- ☐ High stress / over-thinking everything / ADD / ADHD / anxiety
- ☐ Irritable, angry & frustrated frequently
- ☐ Mental sluggishness / fogginess
- ☐ Mood swings / suffer from depression
- ☐ Cold hands / feel cold all the time
- ☐ Hot flashes & night sweats
- ☐ Thirsty all the time
- ☐ Fast heart beat (>100 beats/min)
- ☐ Slow heart beat (<50 beats/min)
- ☐ Irregular heart beat
- ☐ Palpitations / heart fluttering / tight sensation in the chest
- ☐ Bitter taste in the mouth
- ☐ Skin rashes (redness, itching)
- ☐ Headache at the top & sides of the head, migraines
- ☐ Numbness / tingling sensation
- ☐ Muscle twitching / cramping / spasms
- ☐ Seizures / convulsions, tremors, tics
- ☐ Lump in the throat
- ☐ Neck & shoulder tension / tightness / pain
- ☐ Joint pain
- ☐ TMJ pain
- ☐ High-pitched ringing in ears
- ☐ Difficulty adapting to stress
- ☐ Dizziness / poor balance / vertigo
- ☐ Itchy eyes / burning eyes / dry eyes
- ☐ Fatigue after eating
- ☐ Bruise easily
- ☐ Sore achy/ weak knees
- ☐ Profuse or frequent urination
- ☐ Scanty urination
- ☐ Low back pain
- ☐ Muscle tightness
- ☐ Urinary incontinence
- ☐ Abnormal urination (blood, painful, cloudy)
- ☐ General weakness, low energy, chronic fatigue
- ☐ Low / no libido
- ☐ Excessively high libido

WOMEN ONLY

- ☐ Menstrual cramps
- ☐ Irregular cycle
- ☐ Premenstrual syndrome
- ☐ Headaches - premenstrually or menstrual