Anne Tse Acupuncture

Confidential Health History

Welcome! Please take the time to fill out this questionnaire fully. Your answers are strictly confidential. If you have any questions, please feel free to ask.

Today's Date _____ Health Plan _____ Member ID _____

Name _____ Age _____ Date of Birth _____

Address_____ City _____ State _____ Zip _____

Tel: Home _____ Cell_____ Work _____

Ok for me to send you appointment reminders via text message? ❑ Y ❑ N

E-mail _____ Height _____ Weight _____ Sex: ❑ M ❑ F

Occupation_____ Referred by _____

Name & Tel# of Physician _____ok for me to contact? ❑ Y ❑ N

Emergency Contact Name & Tel# _____ Relationship _____

Who referred you? _____

What would you like treated by acupuncture? _____

How long have you had this condition? _____ The onset was ❑ Sudden or ❑ Gradual?

What were the circumstances? _____

What medical diagnosis have you received, if any? _____

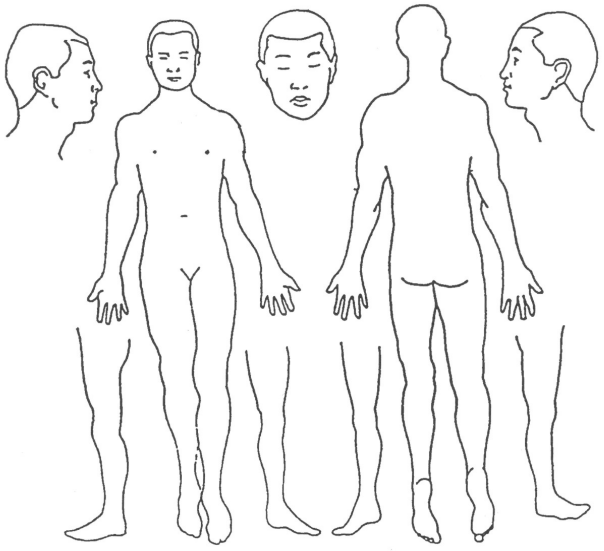
What kinds of treatment or therapy have you tried? _____

How has this condition affected your daily activities? _____

What makes this condition better? _____ worse? _____

Are you currently pregnant? _____ Are you presently trying to become pregnant? _____

Please shade any areas of pain or distress on the diagram below:



Medical History Please check off any current or former conditions

❑ AIDS/HIV	❑ Asthma/ Bronchitis	❑ Cancer/Tumor	❑ Allergies
❑ Hepatitis A/B/C	❑ Emphysema	❑ Lymph Nodes removed	❑ Diabetes
❑ Herpes	❑ Tuberculosis	❑ Organ Transplant/ Removed	❑ Thyroid disease
❑ Lyme disease	❑ Heart Disease	❑ Osteoarthritis	❑ Seizures
❑ Multiple Sclerosis	❑ Pacemaker	❑ Rheumatoid Arthritis	❑ Other_____

Please describe any significant accidents, injuries, trauma, illnesses, and surgeries:

Birth trauma, if any _____

Scars from injury/surgery (even minor):

_____

Medications Please list all medications (including over-the counter), herbs, vitamins and minerals you are taking.

_____

_____

Family Medical History Please indicate any disorders in your close family.

❑Allergies	❑Blood Disorders	❑Diabetes	❑Stroke
❑Cancer	❑Drug Abuse	❑Heart Disease	
❑High Blood Pressure	❑Orthopedic Disorders	❑Psychological Disorders	

Please (Circle) any condition you have now, and <u>Underline</u> any condition you have had in the past.

Musculoskeletal: Muscle pain/ tightness/ cramping. Repetitive strain. Tendonitis. Arthritis/Joint pain. Rheumatism. Swollen joints. Bone pain. Where? _____

Gastro-intestinal: How often do you move your bowels? _____

Respiratory, Eyes, Ears, Nose, Throat, & Head:

Do you smoke cigarettes? _____day/wk, for _____years ❑ Alcoholism/ Drug Abuse

❑ Chronic cough. ❑ Chronic runny / stuffy nose / Sinus Infections

❑ Painful/Red eyes ❑ Ear pain/infections/ Poor hearing ❑ Gum problems

Frequent headaches/migraines describe _____

Cardiovascular: Have you been diagnosed with any heart trouble? _____

❑ Chest pressure or pain. ❑ High / Low blood pressure

Skin, Hair, Nails:

❑ Rashes / Itching ❑ Acne ❑ Sweaty hands/ feet Other:_____

Urinary:

❑ Frequent urination ❑ Painful urination ❑ Urinary tract infections ❑ Kidney stones

Do you wake at night to urinate? _____ other_____