Acupuncture Health History Form

Benessere Acupuncture & Massage
In the comfort of your own Home

Please take time to fill out this questionnaire carefully. The information you provide will assist me in formulating a complete health profile for you. All of your answers are absolutely confidential. If you have questions, please ask.

Name: _____Date:_____

Address:_____

City: _____State:_____Zip:_____

Home Phone:_____Work_____Cell:_____

E-mail:_____

Date of Birth: _____ Age: _____ Marital Status: _____

Occupation: _____ Referred by: _____

In Emergency Notify_____ Phone: _____

Main Complaint (symptoms, diagnosis, duration, etc.)_____

_____

What are your goals/concerns for today's session_____

_____

Significant Trauma (physical, emotional)_____

Surgeries (please include date of procedure)_____

Allergies (chemical, environmental, food, drugs, etc.)_____

_____

Medications/Vitamins/Supplements/Herbs_____

I hereby request and consent to the performance of acupuncture and other procedures within the scope of practice of Traditional Chinese Medicine on myself (or the patient named below for whom I am legally responsible for) by Barbara Williams, AP. I understand and have been informed that, as in the practice of acupuncture, there are some risks to treatment, including but not limited to possible bruising, possible hematoma, residual soreness, nausea or infection. In the practice of cupping; possible bruising, in the practice of moxibustion; possible burns and in the practice of massage and acupressure; possible soreness. I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, by signing below I agree to the above named procedures. I intend this consent form to cover the entire course of treatment for my present condition(s) and for any future condition(s) for which I seek treatment.

Client Signature:_____Date:_____

Parent or Guardian Signature
(in case of a minor):_____Date:_____

Personal History Please check any conditions or symptoms you have or have had.

- ☐ Arthritis
- ☐ Liver/Gall Bladder Disease
- ☐ Stroke
- ☐ Heart Disease
- ☐ High/Low Blood Pressure
- ☐ Hypo/Hyperglycemia
- ☐ Kidney Disease
- ☐ High Cholesterol
- ☐ Cancer
- ☐ Diabetes
- ☐ Food Allergies/Intolerance
- ☐ IBS/Diverticulitis
- ☐ Ulcer
- ☐ Seizures
- ☐ Hepatitis
- ☐ Raynaud's Disease
- ☐ Chronic Fatigue
- ☐ Anemia
- ☐ Thyroid Imbalance
- ☐ Respiratory Allergies
- ☐ Alcoholism
- ☐ Lyme Disease
- ☐ Chronic Pain Condition
- ☐ Impotence
- ☐ Gastritis/Pancreatitis
- ☐ Asthma
- ☐ Infertility
- ☐ Emphysema

Family Medical History Please check any condition that applies to your immediate family.

- ☐ Diabetes
- ☐ High Blood Pressure
- ☐ Other_____
- ☐ Seizures
- ☐ Allergies
- ☐ Heart Disease
- ☐ Cancer
- ☐ Stroke
- ☐ Asthma

Please check the appropriate box if you have experience any of the following within the last 3 months.

General Symptoms:

- ☐ Poor Appetite
- ☐ Poor Sleep
- ☐ Fatigue
- ☐ Fever
- ☐ Heavy appetite
- ☐ Sweat Easily
- ☐ Poor Balance
- ☐ Cold hands or feet
- ☐ Strongly like hot drinks
- ☐ Dental/gum problems
- ☐ Peculiar tastes/ smells
- ☐ Night Sweats
- ☐ Strongly like cold drinks
- ☐ Bodily heaviness
- ☐ Weight loss/gain
- ☐ Tremors weakness/fatigue
- ☐ Muscle Weakness/Fatigue
- ☐ Sudden energy drop
- ☐ Change in appetite
- ☐ Bleed/Bruise easily

Skin and Hair:

- ☐ Rashes
- ☐ Ulcerations
- ☐ Hives/Allergic Dermatitis
- ☐ Itching
- ☐ Eczema/Psoriasis
- ☐ Dandruff
- ☐ Loss of hair
- ☐ Recent moles
- ☐ Skin discoloration
- ☐ Acne
- ☐ Change in texture
- ☐ Face flushing
- ☐ Dermatitis
- ☐ Warts
- ☐ Fungal Infections

Head, Eyes, Ears, Nose and Throat:

- ☐ Eye Strain
- ☐ Eye Pain
- ☐ Color blindness
- ☐ Cataracts
- ☐ Spots in front of eyes
- ☐ Poor Vision
- ☐ Ringing in Ears
- ☐ Poor Hearing
- ☐ Earaches
- ☐ Recurrent sore throat/Cold
- ☐ Dental Problems
- ☐ Migraines
- ☐ Headaches
- ☐ Difficulty swallowing
- ☐ Grinding teeth
- ☐ Sores on lips/tongue
- ☐ Nose bleeds
- ☐ Sinus Problems
- ☐ Facial Pain
- ☐ Jaw Clicks/locks
- ☐ Dizziness
- ☐ Blurred Vision

Cardiovascular

- ☐ Chest pain or pressure
- ☐ swelling of hands/feet
- ☐ Blood clots
- ☐ Phlebitis
- ☐ High blood Pressure
- ☐ Varicose/spider veins
- ☐ Pressure in chest
- ☐ Shortness of breath
- ☐ Low blood pressure
- ☐ Spontaneous sweating
- ☐ Dizziness
- ☐ Irregular heart beat
- ☐ Palpitations at rest
- ☐ Fainting

Respiratory

- ☐ Cough/Wheezing
- ☐ Pneumonia
- ☐ Coughing blood
- ☐ Pain with deep inhalation
- ☐ Asthma
- ☐ Tight sensation in chest
- ☐ Bronchitis
- ☐ Difficult inhale
- ☐ Difficult exhale
- ☐ Production of phlegm
- ☐ Difficult breathing laying down

Gastrointestinal

- ☐ Nausea
- ☐ Gas
- ☐ Indigestion
- ☐ Bloating/Edema
- ☐ Changes in appetite
- ☐ Excessive appetite
- ☐ Vomiting
- ☐ Belching
- ☐ Bad breath
- ☐ Chronic laxative use
- ☐ Diarrhea
- ☐ Constipation
- ☐ Black stools
- ☐ Blood in stool
- ☐ Rectal Pain
- ☐ Mucous in stool
- ☐ Loose stools
- ☐ Abdominal pain/Cramps
- ☐ Acid reflux//GERD
- ☐ Hernia
- ☐ Hemorrhoids
- ☐ Significant thirst
- ☐ IBS/Crohn's Disease

Genito-Urinary

- ☐ Pain on urination
- ☐ Unable to hold urine
- ☐ Frequent urination
- ☐ Urgent urination
- ☐ Urinary tract infection
- ☐ Night urination-How often?_
- ☐ Blood in urine
- ☐ Kidney stones
- ☐ Scanty urine flow
- ☐ Dribbling after urination
- ☐ Copious urine flow
- ☐ Premature ejaculation
- ☐ Burning urination
- ☐ Decreased libido
- ☐ Prostatitis
- ☐ Sores on genitals
- ☐ Impotence
- ☐ Nocturnal emission
- ☐ Pain in testicles
- ☐ Herpes
- ☐ Infections

Gynecological/Reproductive

- ☐ Difficult/Painful intercourse
- ☐ Vaginal Dryness
- ☐ Vaginal sores
- ☐ Vaginal Discharge
- ☐ Infertility
- ☐ Irregular Menstruation
- ☐ Ovarian cysts
- ☐ Endometriosis
- ☐ Fibrocystic breast tissue
- ☐ Uterine Fibroids
- ☐ Polycystic Ovarian Syndrome
- ☐ PMS
- ☐ Painful menstruation
- ☐ Age of first menses_____
- ☐ Date of last menses_____
- ☐ Date of last PAP/Pelvic_____
- ☐ Number of pregnancies_____
- ☐ Number of live births_____
- ☐ Number of ectopic pregnancies_____
- ☐ Number of miscarriages_____
- ☐ Number of abortions_____
- ☐ Do you practice birth Control?_____
- What type?_____
- For how long?_____

Musculoskeletal

- ☐ Neck pain
- ☐ Knee pain
- ☐ Limited range of motion
- ☐ Bursitis
- ☐ Shoulder pain
- ☐ Hand/wrist pain
- ☐ Sprains/Strains
- ☐ Carpal tunnel
- ☐ Hip pain
- ☐ Foot/ankle pain
- ☐ Muscle pain
- ☐ Tendonitis
- ☐ Back pain
- ☐ Muscle weakness
- ☐ Sciatica
- ☐ Rotator cuff

Neuropsychological

- ☐ Seizures
- ☐ Nervousness
- ☐ Bad temper/irritable
- ☐ ADD/ADHD
- ☐ Lack of coordination
- ☐ Depression
- ☐ Easily stressed
- ☐ Anxiety/panic attacks
- ☐ Seasonal Affective Disorder
- ☐ Seeing a therapist
- ☐ Poor memory
- ☐ Areas of numbness