COMPLETE HEALTH Acupuncture Supplement Intake Forms

Name: ____ **Date:** _______________

MAIN COMPLAINT AND PRESENT MEDICAL HISTORY

Main concern you would like us to help you with:

____

____

____

When did this problem begin?

____

Has another medical professional diagnosed you for this problem? Yes/No If yes, what?

____

What kinds of treatment have you tried so far? What were the results?

____

Are you currently receiving treatment for your condition? Yes/No If yes, please describe:

____

To what extent does this condition interfere with your daily activities? (e.g. work, sleep, appetite, sex, etc)

____

PAST MEDICAL HISTORY

Illnesses (*with dates*):

____

____

____

Surgeries (*with dates*):

____

Significant Trauma (*Auto accidents, falls, etc., with dates*)

____

____

Do you have, or have you had, any Infectious Diseases? Yes/No If yes, please describe:

____

____

CURRENT MEDICATIONS: (*Please list ALL prescription, over-the-counter drugs, vitamins, herbs, etc.*)

____

____

ALLERGIES:

____

FAMILY MEDICAL HISTORY (GENERAL HEALTH)

Maternal Side: ____

Paternal Side: ____

Siblings: ____

If any of the above listed are deceased, what was the cause? ___________________________

PERSONAL HISTORY

Birthing History (prolonged labor, pre-term birth, forceps delivery, etc.) ____________________

Childhood Illnesses ____

Current Predominant Emotions (Depression, anxiety, stress, etc.) ______________________________

Hobbies and recreational habits: ____

Do you have a regular exercise program? Yes/No If yes, please describe:

____

Have you traveled abroad in the past year? Yes/No If yes, where? ____________________________

Do you smoke? Yes/No How often? __________ Do you drink alcohol? Yes/No How often? __________

PLEASE CHECK OFF IF YOU HAVE EXPERIENCED ANY OF THE FOLLOWING *IN THE PAST SIX MONTHS*

☐ Fevers ☐ Chills ☐ Poor Appetite ☐ Poor Balance ☐ Fatigue ☐ Night Sweats ☐ Day Sweating

☐ Tremors ☐ Poor Sleep/Insomnia ☐ Dream Disturbed Sleep ☐ Strong thirst for Hot or Cold drinks

☐ Weight Loss ☐ Weight Gain ☐ Sudden energy drops-What time of day? ________

☐ Joint Pain ☐ Localized Weakness-where? __________ ☐ Bleeding or Bruising

NEUROPSYCHOLOGICAL *(please check all that apply)*

☐ Seizures ☐ Areas of Numbness ☐ Anxiety ☐ Concussion ☐ Lack of Coordination

☐ Poor Memory ☐ Dizziness ☐ Loss of Balance ☐ Easily Angered ☐ Headaches ☐ Fainting

☐ Depression ☐ Migraines ☐ Disorientation ☐ Mania ☐ Easily Susceptible to Stress

Have you ever been treated for emotional problems? Yes/No If yes, please describe:__________________

Women Only: **PREGNANCY & GYNECOLOGY**

Age at First Menses: ___ years old Period between menses cycles: _____ days Duration of Menses: _____ days

Number of pregnancies:____ Number of Births: ____ what type?_________ Miscarriages:___how long?______

Birth Control? Yes/No If yes, what type? ________

Please check any that apply:

Abortions Fertility Problems Heavy or Light Periods Difficult Births Vaginal Discharge

Irregular Periods Breast Lumps Vaginal Sores Painful Periods Clots PMS

First Date of Last Menstrual Cycle ____/____/____ Date of Last Pap Smear ____/____/____

Are you currently Pregnant? Yes/No

Men Only: *Please check all that apply*: ☐ Impotency ☐ Difficulty in Erection or Ejaculation ☐ Testicle Pain or Swelling

CARDIOVASCULAR (*please check all that apply*)

☐ High Blood Pressure ☐ Dizziness ☐ Swelling of Hands ☐ Blood Clots ☐ Irregular Heartbeat

☐ Fainting ☐ Difficulty Breathing ☐ Palpitations ☐ Low Blood Pressure ☐ Cold Sweats

☐ Cold Hands/Feet ☐ Chest Pain ☐ Swelling of Feet ☐ Phlebitis

RESPIRATORY (*please check all that apply*)

☐ Cough ☐ Pain with Deep Breaths ☐ Difficulty in Breathing ☐ Asthma ☐ Bronchitis

☐ Shortness of Breath ☐ Easily Winded w/ Exertion when laying down ☐ Coughing Blood

☐ Production of phlegm- what color?_______________

GASTROINTESTINAL *(please check all that apply)*

☐ Nausea ☐ Abdominal Pain/Cramps ☐ Digestive Disorders ☐ Vomiting ☐ Parasites

☐ Constipation ☐ Indigestion ☐ Belching ☐ Diarrhea ☐ Ulcers ☐ Bad Breath

☐ Blood in Stools ☐ Hernia ☐ Hemorrhoids

GENITO-URINARY *(please check all that apply)*

☐ Pain on Urination ☐ Decrease in Urine Kidney Stones ☐ Urgent urination ☐ Blood in Urine

☐ Frequent Urination ☐ Waking up to Urinate ☐ Genital Sores