



Unity Acupuncture & Herbal Medicine

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HEALTH HISTORY

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

Name: _____ <small>(first) (middle) (last)</small>	Date: _____	
Date of Birth: _____	Pronoun: _____	Age: _____
Address: _____		
City: _____	State: _____	Zip: _____
Best Phone: _____	Other Phone (please specify): _____	
E-Mail: _____		
Relationship Status: _____	Your Occupation: _____	
Physician: _____	Phone: _____	
In Emergency Notify: _____	Phone: _____	
How did you hear about Unity Acupuncture and Herbal Medicine? _____		
Referred by: _____		
Have you tried acupuncture before (circle one)? Yes No		

What is your MAIN CONCERN? _____

Symptoms _____

Western Diagnosis, if any: _____

When did you first notice symptoms? _____

What makes your condition better? _____

What makes your condition worse? _____

GENERAL HISTORY

Significant Trauma (physical or emotional; please list age or date)

Your Birth History (prolonged labor, forceps delivery, C-section delivery, complications, postpartum depression in mother, etc.)

Childhood Illness: Mumps Measles Rubella Diphtheria Chicken Pox Rheumatic Fever Polio
Other:

Do you have any infectious diseases? Yes No **If yes, please identify:** _____

Hospitalizations/Surgeries/Accidents (please include date of procedure)

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

Medications (names & dosages) Please attach an additional page if necessary.

Vitamins/Supplements/Herbs (with dosages, if you know them)

Exercise

Days per week Length of workout Type of Activity

Diet

Meals per day Snacks Cravings Are you happy with your weight?

Beverages (list # of cups/cans per day)

Coffee Tea Soda Alcohol (drinks per week)

Tobacco/Drugs

Tobacco Type: Amount: # of years:

Recreational Drugs Type: Frequency:

Stress level Low Med High

Do you have adequate physical and emotional support at home to meet the challenges of your present condition? Yes No

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

- | | | | |
|---|---|---|---|
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> High/Low Blood Pressure | <input type="checkbox"/> High Cholesterol |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hyper/Hypothyroidism | <input type="checkbox"/> Food Allergies/Intolerance |
| <input type="checkbox"/> Gastritis/Pancreatitis | <input type="checkbox"/> Irritable Bowel Syndrome | <input type="checkbox"/> Crohn's Disease | <input type="checkbox"/> Diverticulitis |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Chronic Fatigue | <input type="checkbox"/> Anemia | <input type="checkbox"/> Raynaud's Disease | <input type="checkbox"/> Lyme Disease |
| <input type="checkbox"/> Chronic Pain Condition | <input type="checkbox"/> Asthma | <input type="checkbox"/> Respiratory Allergies | <input type="checkbox"/> Emphysema |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Lupus | <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> Osteoarthritis |
| <input type="checkbox"/> Infertility | <input type="checkbox"/> Impotence | <input type="checkbox"/> Alcoholism/Substance Abuse | <input type="checkbox"/> Other: _____ |

General

- | | | | |
|---|---|---|---|
| <input type="checkbox"/> Fever | <input type="checkbox"/> Poor Sleeping | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Peculiar tastes/smells |
| <input type="checkbox"/> Chills | <input type="checkbox"/> Night Sweats | <input type="checkbox"/> Sweats Easily | <input type="checkbox"/> Tremors |
| <input type="checkbox"/> Frequent colds or flus | <input type="checkbox"/> Localized Weakness | <input type="checkbox"/> Change in appetite | <input type="checkbox"/> Dizziness |
| <input type="checkbox"/> Bleed/Bruise easily | <input type="checkbox"/> Weight loss/gain | <input type="checkbox"/> Strong thirst | <input type="checkbox"/> Sudden energy drop |

Skin and Hair

- | | | | |
|---|--------------------------------------|--|---|
| <input type="checkbox"/> Rashes | <input type="checkbox"/> Ulcerations | <input type="checkbox"/> Hives/Allergic Dermatitis | <input type="checkbox"/> Itching |
| <input type="checkbox"/> Eczema/Psoriasis | <input type="checkbox"/> Dandruff | <input type="checkbox"/> Hair Loss | <input type="checkbox"/> Recent moles |
| <input type="checkbox"/> Skin discoloration | <input type="checkbox"/> Acne | <input type="checkbox"/> Change in skin/hair texture | <input type="checkbox"/> Face flushing |
| <input type="checkbox"/> Dermatitis | <input type="checkbox"/> Warts | <input type="checkbox"/> Fungal Infection | <input type="checkbox"/> Weak or ridged nails |

Head, Eyes, Ears, Nose and Throat

- | | | | |
|---|---|---|--|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Migraines | <input type="checkbox"/> Glasses | <input type="checkbox"/> Tearing/Dry Eyes |
| <input type="checkbox"/> Eye Strain | <input type="checkbox"/> Eye pain | <input type="checkbox"/> Poor vision | <input type="checkbox"/> Night Blindness |
| <input type="checkbox"/> Spots in front of eyes | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Cataracts | <input type="checkbox"/> Blurred vision |
| <input type="checkbox"/> Earaches | <input type="checkbox"/> Ringing in ears | <input type="checkbox"/> Poor hearing | <input type="checkbox"/> Sinus problems |
| <input type="checkbox"/> Nose bleeds | <input type="checkbox"/> Recurrent sore throats/colds | <input type="checkbox"/> Grinding teeth | <input type="checkbox"/> Facial pain |
| <input type="checkbox"/> Sores on lips/tongue | <input type="checkbox"/> Dental/gum problems | <input type="checkbox"/> TMJ/Jaw clicks/locks | <input type="checkbox"/> Difficulty swallowing |

Cardiovascular

- | | | | |
|--|---|---|--|
| <input type="checkbox"/> Chest pain | <input type="checkbox"/> Irregular heart beat | <input type="checkbox"/> Palpitations at rest | <input type="checkbox"/> Fainting |
| <input type="checkbox"/> Cold hands/feet | <input type="checkbox"/> Swelling of hands/feet | <input type="checkbox"/> Blood clots | <input type="checkbox"/> Phlebitis |
| <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Varicose/spider veins | <input type="checkbox"/> Pressure in chest | <input type="checkbox"/> High blood pressure |
| <input type="checkbox"/> Low blood pressure | <input type="checkbox"/> Spontaneous sweating | <input type="checkbox"/> Rheumatic fever | <input type="checkbox"/> Heart murmur |

Respiratory

- | | | | |
|---|--|--|--|
| <input type="checkbox"/> Cough/Wheezing | <input type="checkbox"/> Coughing blood | <input type="checkbox"/> Asthma | <input type="checkbox"/> Bronchitis |
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Pain with deep inhalation | <input type="checkbox"/> Tight sensation in chest | <input type="checkbox"/> Difficult inhale/exhale |
| <input type="checkbox"/> Difficulty breathing when lying down | | <input type="checkbox"/> Production of phlegm... what color? _____ | |

Gastrointestinal

- | | | | |
|--|---|---------------------------------------|--|
| <input type="checkbox"/> Nausea | <input type="checkbox"/> Vomiting | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Gas | <input type="checkbox"/> Belching | <input type="checkbox"/> Black stools | <input type="checkbox"/> Blood in stool |
| <input type="checkbox"/> Indigestion | <input type="checkbox"/> Bad breath | <input type="checkbox"/> Rectal pain | <input type="checkbox"/> Hemorrhoids |
| <input type="checkbox"/> Bloating/Edema | <input type="checkbox"/> Chronic laxative use | <input type="checkbox"/> Parasites | <input type="checkbox"/> Abdominal pain/cramps |
| <input type="checkbox"/> Changes in appetite | <input type="checkbox"/> Acid reflux/GERD | <input type="checkbox"/> Hernia | <input type="checkbox"/> Poor appetite |
| <input type="checkbox"/> Excessive appetite | <input type="checkbox"/> Significant thirst | <input type="checkbox"/> Ulcer | <input type="checkbox"/> Gallstones |

Musculoskeletal

- | | | | |
|---|--|---|--|
| <input type="checkbox"/> Neck pain | <input type="checkbox"/> Shoulder pain | <input type="checkbox"/> Hand/wrist pain | <input type="checkbox"/> Carpal Tunnel |
| <input type="checkbox"/> Knee pain | <input type="checkbox"/> Sprains/Strains | <input type="checkbox"/> Sciatica | <input type="checkbox"/> Foot/ankle pain |
| <input type="checkbox"/> Hip pain | <input type="checkbox"/> Muscle pain | <input type="checkbox"/> Muscle weakness | <input type="checkbox"/> Muscle cramps |
| <input type="checkbox"/> Tendonitis | <input type="checkbox"/> Bursitis | <input type="checkbox"/> Rotator Cuff | <input type="checkbox"/> Joint Pain |
| <input type="checkbox"/> Back pain Low ___ Middle ___ Upper ___ | | <input type="checkbox"/> Soreness/weakness in lower body (back, knee, hip, ankle, foot) | |

Neurological

- | | | | |
|---|--|--|--|
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Loss of balance | <input type="checkbox"/> Vertigo/Dizziness | <input type="checkbox"/> Areas of numbness |
| <input type="checkbox"/> Lack of coordination | <input type="checkbox"/> Poor memory | <input type="checkbox"/> Concussion | <input type="checkbox"/> ADD/ADHD |

Emotional

- | | | | |
|---|--|--|--|
| <input type="checkbox"/> Mood Swings | <input type="checkbox"/> Irritability | <input type="checkbox"/> Nervousness | <input type="checkbox"/> Constant Anxiety |
| <input type="checkbox"/> Panic Attacks | <input type="checkbox"/> Situational Anxiety | <input type="checkbox"/> Social Anxiety | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Irrational Fears | <input type="checkbox"/> Lack of Motivation | <input type="checkbox"/> Constant Worrying | <input type="checkbox"/> Seasonal Affective Disorder |
| <input type="checkbox"/> Obsessive Behavior | <input type="checkbox"/> Anger | <input type="checkbox"/> Manic Depression | <input type="checkbox"/> Sadness/Grief |

Have you ever been treated for emotional problems? Yes No
Have you ever considered or attempted suicide? Yes No
Have you ever been treated for substance abuse? Yes No

Genitourinary

Have you experienced menopause? Yes No If yes, when? _____

Are you currently on hormone replacement therapy for menopause (please list all)? _____

Date last cycle began: _____ Length of bleeding cycle (ie 25-35 days): _____ Is your cycle Regular Irregular

Describe your bleed: Heavy Light Average Consistency of blood: Watery Thick Average

Describe the color of your blood: (red, dark red, purple, brownish red, bright red, pink, etc.) _____

Are you currently on a form of birth control (i.e. pill, IUD, etc.)? Yes No

If yes, what form, and which prescription are you on? _____

Do you experience any of the following before or during your bleed?

- | | | | |
|---|--------------------------------------|--|--|
| <input type="checkbox"/> Chest Tenderness | <input type="checkbox"/> Cramps | <input type="checkbox"/> Clots | <input type="checkbox"/> Change in bowel |
| <input type="checkbox"/> Bloating | <input type="checkbox"/> Headache | <input type="checkbox"/> Nausea | <input type="checkbox"/> Moodiness |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Nightsweats | <input type="checkbox"/> Sleep Disturbance | <input type="checkbox"/> Acne |

Are you on any hormones (please list)? Yes _____ No

Have you had any gender-affirming surgeries? Yes No

If yes, have you experienced any surgery complications (please list symptoms)? _____

Do you experience vaginal discharge? Yes No

Is there a foul odor? Yes No

What color: White Yellow Green Pink Red

Consistency: Watery/Thin Thick Sticky

Are you pregnant? Yes No

Are you trying to conceive? Yes No

of pregnancies: _____

of live births: _____

of miscarriages: _____

of abortions: _____

Are you currently undergoing assisted reproductive fertility treatments (IUI, IVF, ICSI, superovulation, etc.)? Yes No

How would you define your sexual energy? Below Normal Normal Above Normal

Have you ever been diagnosed with or experienced:

- | | |
|--|---|
| <input type="checkbox"/> Pelvic Inflammatory Disease | <input type="checkbox"/> Uterine Fibroids |
| <input type="checkbox"/> Pelvic Adhesions | <input type="checkbox"/> Prolapsed Uterus |
| <input type="checkbox"/> Polycystic Ovarian Syndrome | <input type="checkbox"/> Endometriosis |
| <input type="checkbox"/> Frequent Urinary Tract Infections | |

- | | |
|---|---|
| <input type="checkbox"/> Polyps | <input type="checkbox"/> Cervical Dysplasia |
| <input type="checkbox"/> Ovarian Cysts | <input type="checkbox"/> Uterine Cancer |
| <input type="checkbox"/> Ovarian Cancer | |
| <input type="checkbox"/> STDs If yes, please list _____ | |

Have you ever been diagnosed with or experienced:

- | | |
|--|--|
| <input type="checkbox"/> Undescended Testicle | <input type="checkbox"/> Varicocele |
| <input type="checkbox"/> Premature Ejaculation | <input type="checkbox"/> Nocturnal Emission |
| <input type="checkbox"/> Genital Itch | <input type="checkbox"/> Small or Soft Testes |
| <input type="checkbox"/> Decrease in urine flow | <input type="checkbox"/> Stop and start urine flow |
| <input type="checkbox"/> Urinary Tract Infection | <input type="checkbox"/> Kidney Stones |

- | | |
|---|---|
| <input type="checkbox"/> Erectile Dysfunction | <input type="checkbox"/> Difficulty Ejaculating |
| <input type="checkbox"/> Penile Discharge | <input type="checkbox"/> Sores on Genitals |
| <input type="checkbox"/> Prostate Conditions | <input type="checkbox"/> Incontinence |
| <input type="checkbox"/> Blood in Urine | <input type="checkbox"/> Burning or Painful Urination |
| <input type="checkbox"/> STDs If yes, please list _____ | |

Is there anything I should know about your health? _____