Sabrina Kirkland Acupuncture

Patient Health History

Date: ____/____/____

First Name: _____ **Middle Initial:**_____ **Last Name:** _____

Date of Birth: ____/____/____ **Age:** _____ **Gender:** (M | F)____ **Marital Status:** _____

Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Primary Telephone: _____ **Alternate Telephone:** _____
(Home, Work, Cell) *(Home, Work, Cell)*

Email Address: _____

Occupation: _____ **How Many Years?** _____

Emergency Contact(s): _____ **Phone:** _____
_____ **Phone:** _____

Primary Medical Provider(s): _____ **Phone:** _____
Other Healthcare Provider: _____ **Phone:** _____

How Did You Find Us? _____

Please complete this questionnaire as thoroughly as possible. Print all information and indicate areas of confusion with a question mark. Successful health care and preventative medicine are only possible when the practitioner has a complete understanding of the patient physically, mentally and emotionally. Thank you!

1. When and where did you last receive health care?_____

For what reason?_____
_____

2. Identify the health concerns that have brought you here today. List in order of most extreme.
(*Use diagrams below to indicate areas specified in section A & B*)

A.

_____
_____
_____
_____

How does this condition affect you?

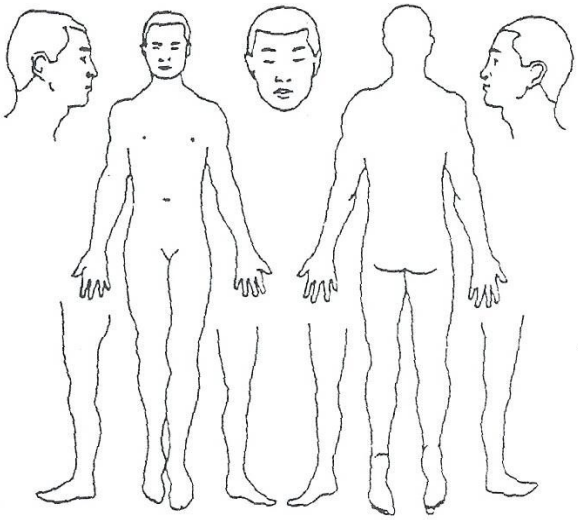
_____
_____
_____
_____
_____

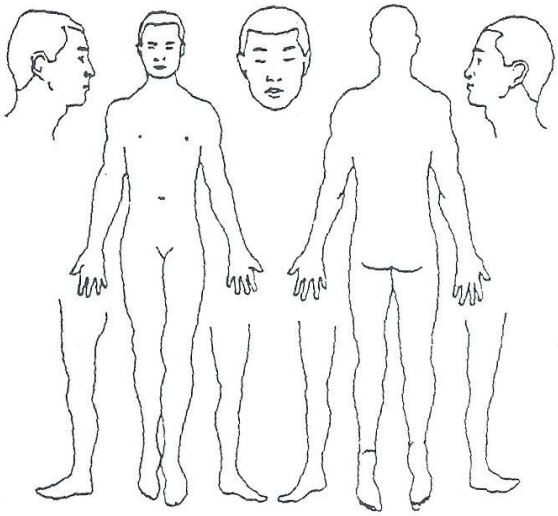
B.

_____
_____
_____
_____

How does this condition affect you?

_____
_____
_____
_____
_____





3. List all foods, drugs, or medications you are hypersensitive or allergic to: (*Please include reaction*)

_____

_____

4. Please list any medications, vitamins, and supplements you're currently taking:
(*Prescribed / Over-the-counter*) _____

_____

5. Height: _____ **Current Weight**: _____ **Past Maximum:** _____ **How Long Ago?** _____

6. What is your most recent blood pressure reading? ____/____ **When was this taken?** _____

7. Immunizations Received:
(*Please check any that you have received*)

- ❑ Polio
- ❑ Tetanus
- ❑ Rubella/Mumps/Rubella
- ❑ Pertussi
- ❑ Diphtheria
- ❑ Hepatitis B
- ❑ Other(s):_____

8. Family History:
(*Please check all that apply and designate if Self / Mother / Father / Other*)

- ❑ Cardiac Pacemaker
- ❑ Heart Attack
- ❑ Seizure Disorder
- ❑ Stroke
- ❑ Bleeding Disorder
- ❑ Diabetes
- ❑ Fainting Disorder
- ❑ Cancer
- ❑ HIV
- ❑ Rheumatoid Arthritis
- ❑ Hepatitis B or C
- ❑ Other:_____

9. Hospitalizations or Surgeries: (*Please including when and why*)

_____

_____

10. Is there anything else I should know? _____

_____

11. Put a checkmark by the symptoms that currently pertain to you and / or put a 'P' for past symptom:
(*Check all that apply*)

- ❑ Cold hands / feet
- ❑ Diarrhea alternating with constipation
- ❑ Varicose veins
- ❑ Tight feeling in the chest
- ❑ Fatigue
- ❑ Bitter taste in the mouth
- ❑ Hot flashes
- ❑ Bloodshot eyes / dry eyes
- ❑ Heat sensations in the hands, feet, chest
- ❑ Anger easily

- ❑ Night sweating
- ❑ Skin rashes
- ❑ Catch cold easily
- ❑ Headache
- ❑ Sweat easily
- ❑ Numbness of hands and feet
- ❑ Dizziness
- ❑ Muscle spasms, twitching, cramping
- ❑ See floating black spots
- ❑ Seizure / convulsions
- ❑ Mood swings
- ❑ Sore, cold weak knees
- ❑ Heart murmur
- ❑ Low back pain
- ❑ High blood pressure
- ❑ Frequent urination
- ❑ Palpitations
- ❑ Get up more than once a night to urinate
- ❑ Sores on the tip of tongue
- ❑ Lack of bladder control
- ❑ Anxiety & nervousness
- ❑ Memory problems
- ❑ Chest pain radiating to shoulder
- ❑ Hair loss
- ❑ Ankle swelling
- ❑ Ringing in ears (low pitch)
- ❑ Insomnia
- ❑ Bruise easily
- ❑ Difficult breathing
- ❑ Slow healing wounds
- ❑ Cough
- ❑ TMJ / grinding teeth
- ❑ Sinus congestion or pressure
- ❑ Shortness of breath (inhale or exhale)
- ❑ Dry mouth, throat, nose or skin
- ❑ Low appetite
- ❑ Allergies / hay fever
- ❑ Loose stools
- ❑ Chronic infections
- ❑ Constipation
- ❑ Asthma
- ❑ Abdominal bloating or gas after eating
- ❑ Frequent sore throats
- ❑ Feeling tired after eating
- ❑ Chills with alternation fever
- ❑ Prolapsed organs (previously diagnosed)
- ❑ Stiff neck / shoulders
- ❑ General feeling of heaviness in the body
- ❑ Mental sluggishness/
- ❑ Forgetfulness/exhaustion
- ❑ Swollen hands / feet
- ❑ Burning sensation after eating
- ❑ Large appetite
- ❑ Bad breath
- ❑ Mouth sores (canker sores)
- ❑ Bleeding, swollen painful gums
- ❑ Heartburn / belching
- ❑ Hemorrhoids
- ❑ Stomach pain / stomach ulcer
- ❑ Vomiting

Libido (*Sex drive*)

- ❑ Normal
- ❑ Low
- ❑ High

Urination is: (*Check all that apply*)

- ❑ Normal color (pale yellow)
- ❑ Clear
- ❑ Dark yellow
- ❑ Reddish
- ❑ Cloudy
- ❑ Scanty
- ❑ Has odor
- ❑ Burning
- ❑ Painful
- ❑ Difficult
- ❑ Urgent
- ❑ History of urinary-tract infection

Women Only

Are your currently pregnant now? (Y or N)___
Number of children: _____ Number of pregnancies:_____ Age of first period: _____
Menstrual Cycle: _____ Average number of days of flow:_____ The flow is normal/ heavy /light:_____

The color is: (*Check all that apply*)

- ❑ Normal
- ❑ Dark
- ❑ Purple
- ❑ Light brown
- ❑ Brown
- ❑ Bright red
- ❑ Light red
- ❑ Pin

Please answer each question: (*Check all that apply*)

- ❑ Perimenopausal symptoms or
- ❑ Menopause

- ❑ Difficulty conceiving
- ❑ Irregular cycle
- ❑ Breast lumps / tenderness
- ❑ Vaginal discharge
- ❑ Premenstrual symptoms (PMS)
- ❑ Nipple discharge
- ❑ Heavy flow
- ❑ Bleeding between cycles
- ❑ Clotting
- ❑ Painful periods
- ❑ Extreme fatigue during or after period

Please include any additional information related to your menstrual cycle:_____

_____

Men Only

Please answer each question: (*Check all that apply*)

- ❑ Feeling of coldness or numbness in the external genitalia
- ❑ Pain or swelling of testicles
- ❑ Premature ejaculation
- ❑ Impotence / erectile dysfunction

12. Lifestyle:

Do you typically eat at least three meals per day? (Y or N)___ **If no, how many?** _____

Exercise Routine: _____ **Spiritual practice**: _____

How many hours per night do you sleep? _____ **Do you wake rested?** (Y or N)___

Level of education completed:

- ❑ High School
- ❑ Bachelors
- ❑ Masters
- ❑ Doctorate
- ❑ Other: _____

Occupation: _____ **Employer:** _____ **Work Hours/Week:** _____

Do you enjoy work? (Y or N)___ **Why or Why not?** _____

Do you use Nicotine, Alcohol, Caffeine: (Y or N)___ (*Specify which use and how often*) _____

_____

Have you experienced any major traumas? (Y or N)___ (*Explain*)

_____

_____

How many glasses of non-caffeinated, non-carbonated beverages do you drink per day? _____

Interests and hobbies: _____

_____

If there was one thing you could do, make, or create, given all the resources you needed to succeed, what would it be and what would you do?

_____

_____

13. I am Interested in: (*Please check all that apply*)

- ❑ Nutrition
- ❑ Weight Loss
- ❑ Detoxification
- ❑ Hormone and NT
- ❑ Balancing
- ❑ Newsletter
- ❑ Spiritual
- ❑ Advancement
- ❑ Local Events
- ❑ Suggestion