

Concord Center Acupuncture  
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### Health History

Name: \_\_\_\_\_ Date: \_\_\_\_\_  
Street: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_  
Zip Code: \_\_\_\_\_ Day Phone: \_\_\_\_\_ Evening Phone: \_\_\_\_\_  
Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Age: \_\_\_\_ Gender: M / F Email: \_\_\_\_\_  
Height: \_\_\_\_\_ Weight (current): \_\_\_\_\_ Weight (past maximum): \_\_\_\_\_

Please identify the health concerns that you would like us to help you with in order of importance:

1. \_\_\_\_\_ When did this problem begin? \_\_\_\_\_

Medical diagnosis: \_\_\_\_\_

How does this condition interfere with daily activities such as work, sleep, and sex? \_\_\_\_\_

What types of treatment you have tried? \_\_\_\_\_

2. \_\_\_\_\_ When did this problem begin? \_\_\_\_\_

Medical diagnosis: \_\_\_\_\_

How does this condition interfere with daily activities such as work, sleep, and sex? \_\_\_\_\_

What types of treatment you have tried? \_\_\_\_\_

3. \_\_\_\_\_ When did this problem begin? \_\_\_\_\_

Medical diagnosis: \_\_\_\_\_

How does this condition interfere with daily activities such as work, sleep, and sex? \_\_\_\_\_

What types of treatment you have tried? \_\_\_\_\_

When were you last seen by a physician? \_\_\_\_\_ For what reason? \_\_\_\_\_

What is your most recent blood pressure reading? \_\_\_\_\_ When was this taken? \_\_\_\_\_

Do you have any reason to believe that you are pregnant? Y / N

Do you have any infection diseases? Y / N If yes, please identify: \_\_\_\_\_

Do you have a pace maker? Y / N

Do you have any metal implants? Y / N

Please list any food, drugs, medications or substances to which you are hypersensitive or allergic:

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Please list all medications (prescribed and over-the-counter), vitamins, and supplements you are currently taking and the reason for their use:

**Medication/Supplement**

**Dose**

**Reason for taking**

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Please list all hospitalizations and surgeries you have had during the course of your lifetime:

**Date**

**Procedure**

**Reason**

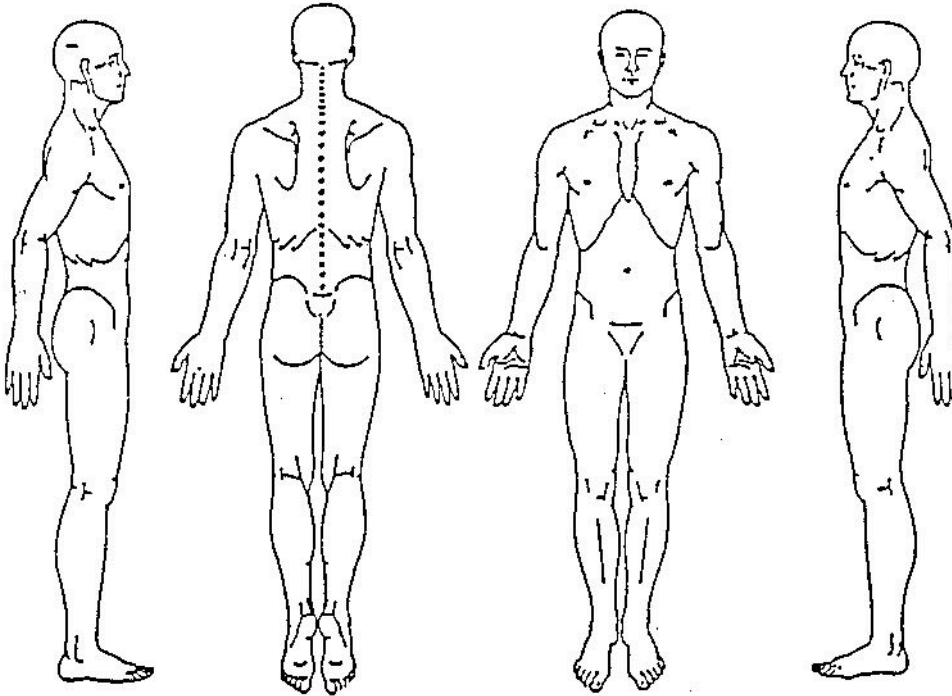
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Please indicate any painful or distressed areas by circling the area.



### Lifestyle

How many meals per day do you typically eat?

Please describe your typical breakfast, lunch, dinner and snacks:

Breakfast:

Lunch:

Dinner:

Snacks:

How many glasses of water per day do you typically drink

How many cups of caffeinated coffee/tea/soda do you drink each day?

How many alcoholic beverages do you drink per week?

How many cigarettes do you smoke each day?

Do you use any prescription or non-prescription drugs recreationally? Y / N

How often do you exercise? Please describe your exercise routine:

How many hours per night do you sleep? Do you wake rested? Y / N

What is your occupation?

How many hours per week do you work? Do you enjoy your work? Y / N

Circle the highest level of education completed:

Grade School Middle School High School Bachelors Masters Doctorate Post-Doc

Do you have a religious/spiritual practice or community?

List your interests and hobbies:

**Childhood Illnesses** (check all that apply)

Scarlet Fever Diphtheria       Measles       Other: \_\_\_\_\_

Rheumatic Fever       German Measles

Mumps       Chicken Pox

**Immunizations** (check all that apply)

Polio       Pertussis       Hepatitis

Tetanus       Diphtheria       Other: \_\_\_\_\_

Rubella/Mumps       Hib

**Family History**

(check all those that apply to either your grandparents, parents, siblings, spouse or children)

	Grandparents	Parents	Siblings	Spouse	Children
Cancer (specify): _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mental Illness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Insomnia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Alcoholism	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Drug Addiction	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Allergies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**General Health and Immunity** (check all that apply)

<input type="checkbox"/> Fevers	<input type="checkbox"/> Slow Wound Healing	<input type="checkbox"/> Cancer (specify): _____
<input type="checkbox"/> Sweat Easily	<input type="checkbox"/> Chronic Infections	<input type="checkbox"/> HIV/AIDS
<input type="checkbox"/> Night Sweats	<input type="checkbox"/> Bleed or Bruise Easily	
<input type="checkbox"/> Chills	<input type="checkbox"/> Chronic Fatigue Syndrome	
<input type="checkbox"/> Cold Hands	<input type="checkbox"/> Fibromyalgia	
<input type="checkbox"/> Cold Feet	<input type="checkbox"/> Frequent Common Colds	
<input type="checkbox"/> Fatigue	<input type="checkbox"/> Anemia	

**Emotional** (check all that apply)

<input type="checkbox"/> Mood Swings	<input type="checkbox"/> Panic Attacks	<input type="checkbox"/> Apathy
<input type="checkbox"/> Nervousness	<input type="checkbox"/> Depression	<input type="checkbox"/> Sadness
<input type="checkbox"/> Mental Tension	<input type="checkbox"/> Worry	<input type="checkbox"/> Crying
<input type="checkbox"/> Poor Sleep	<input type="checkbox"/> Fear	<input type="checkbox"/> Thoughts of Suicide
<input type="checkbox"/> Nightmares	<input type="checkbox"/> Anger	<input type="checkbox"/> Attempted Suicide
<input type="checkbox"/> Anxiety	<input type="checkbox"/> Rage	<input type="checkbox"/> Other:

**Skin and Hair** (check all that apply)

<input type="checkbox"/> Rashes	<input type="checkbox"/> Hives	<input type="checkbox"/> Changes in Hair Texture
<input type="checkbox"/> Itching	<input type="checkbox"/> Pimples	<input type="checkbox"/> Changes in Skin Texture
<input type="checkbox"/> Psoriasis	<input type="checkbox"/> Recent Moles	<input type="checkbox"/> Other:
<input type="checkbox"/> Eczema	<input type="checkbox"/> Loss of Hair	
<input type="checkbox"/> Ulcerations	<input type="checkbox"/> Dandruff	

**Head, Eye, Ear, Nose and Throat** (check all that apply)

<input type="checkbox"/> Impaired Vision	<input type="checkbox"/> Nose Bleeds	<input type="checkbox"/> Teeth Problems
<input type="checkbox"/> Eye Pain/Strain	<input type="checkbox"/> Impaired Hearing	<input type="checkbox"/> Mouth/Tongue Sores
<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Ear Ringing	<input type="checkbox"/> Headaches
<input type="checkbox"/> Cataracts	<input type="checkbox"/> Earaches	<input type="checkbox"/> Migraines
<input type="checkbox"/> Glasses/Contacts	<input type="checkbox"/> Frequent Sore Throats	<input type="checkbox"/> Concussion
<input type="checkbox"/> Color Blindness	<input type="checkbox"/> Teeth Grinding	<input type="checkbox"/> Sinus Problems
<input type="checkbox"/> Blurry Vision	<input type="checkbox"/> TMJ/Jaw Problems	<input type="checkbox"/> Hay Fever
<input type="checkbox"/> Eye Tearing/Dryness	<input type="checkbox"/> Bleeding Gums	
<input type="checkbox"/> Spots in Front of Eyes	<input type="checkbox"/> Bad Breath	

**Respiratory** (check all that apply)

<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Pleurisy	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Bronchitis	<input type="checkbox"/> Difficulty Breathing	<input type="checkbox"/> Other:
<input type="checkbox"/> Persistent Cough	<input type="checkbox"/> Asthma	
<input type="checkbox"/> Shortness of Breath	<input type="checkbox"/> Emphysema	

**Cardiovascular** (check all that apply)

<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Irregular Heartbeat	<input type="checkbox"/> Phlebitis
<input type="checkbox"/> Palpitations	<input type="checkbox"/> Fainting	<input type="checkbox"/> High Cholesterol
<input type="checkbox"/> Chest Pain	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Arterial Sclerosis
<input type="checkbox"/> Stroke	<input type="checkbox"/> Low Blood Pressure	<input type="checkbox"/> Bleed or Bruise Easily
<input type="checkbox"/> Swollen Ankles/Feet	<input type="checkbox"/> Rheumatic Fever	
<input type="checkbox"/> Swollen Hands	<input type="checkbox"/> Varicose Veins	
<input type="checkbox"/> Heart Murmurs	<input type="checkbox"/> Bloods Clots	

**Gastrointestinal** (check all that apply)

<input type="checkbox"/> Ulcers	<input type="checkbox"/> Nausea/Vomiting	<input type="checkbox"/> Black Stool
<input type="checkbox"/> Changes in Appetite	<input type="checkbox"/> Heartburn/Acid Reflux	<input type="checkbox"/> Chronic Laxative Use
<input type="checkbox"/> Weight Loss	<input type="checkbox"/> Epigastric Disease	<input type="checkbox"/> Rectal Pain/Itching
<input type="checkbox"/> Weight Gain	<input type="checkbox"/> Gallbladder Disease	<input type="checkbox"/> Hemorrhoids
<input type="checkbox"/> Strong Thirst	<input type="checkbox"/> Liver Disease	<input type="checkbox"/> Other:
<input type="checkbox"/> Abdominal Pain	<input type="checkbox"/> Hepatitis B or C	
<input type="checkbox"/> Indigestion	<input type="checkbox"/> Diarrhea	
<input type="checkbox"/> Belching	<input type="checkbox"/> Constipation	
<input type="checkbox"/> Gas	<input type="checkbox"/> Blood in Stool	

**Genito-Urinary Tract** (check all that apply)

<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Unable to Hold Urine	<input type="checkbox"/> Kidney Stones
<input type="checkbox"/> Kidney Stones	<input type="checkbox"/> Urine Dribbling	<input type="checkbox"/> Genital Sores
<input type="checkbox"/> Frequent UTI	<input type="checkbox"/> Frequent Urination	<input type="checkbox"/> Genital Itching
<input type="checkbox"/> Blood in Urine	<input type="checkbox"/> Frequent Urination at Night	
<input type="checkbox"/> Painful Urination	<input type="checkbox"/> Scanty Urine Flow	
<input type="checkbox"/> Urgency to Urinate	<input type="checkbox"/> Profuse Urine Flow	

**Female Reproductive** (check all that apply)

<input type="checkbox"/> Irregular Cycles	<input type="checkbox"/> Difficulty Conceiving	<input type="checkbox"/> Bleeding Between Cycles
<input type="checkbox"/> Vaginal Discharge	<input type="checkbox"/> Nipple Discharge	<input type="checkbox"/> PMS
<input type="checkbox"/> Menopausal Symptoms	<input type="checkbox"/> Menstrual Clots	<input type="checkbox"/> Genital Sores/Itching
<input type="checkbox"/> Breast Lumps	<input type="checkbox"/> Painful Periods	<input type="checkbox"/> Infertility
<input type="checkbox"/> Breast Tenderness	<input type="checkbox"/> Heavy Menstrual Flow	<input type="checkbox"/> Sexually Transmitted Disease
<input type="checkbox"/> Premenstrual Problems	<input type="checkbox"/> Scanty Menstrual Flow	

**Menstrual and Birthing History**

When was you last PAP? _____	What form of birth control do you use? ____
When was your last menstrual period? _____	How many pregnancies have you had? ____
At what age did you first menstruate? ____	How many miscarriages have you had? ____
How many days does your menses last? ____	How many abortions have you had? ____
How many days is your menstrual cycle? ____	How many live births have you had? ____

**Male Reproductive** (check all that apply)

<input type="checkbox"/> Sexual Difficulties	<input type="checkbox"/> Low Sperm Motility	<input type="checkbox"/> Penile Discharge
<input type="checkbox"/> Impotence	<input type="checkbox"/> Prostate Problems	<input type="checkbox"/> Genital Sores/Itching
<input type="checkbox"/> Premature Ejaculation	<input type="checkbox"/> Prostate Cancer	<input type="checkbox"/> Sexually Transmitted Disease
<input type="checkbox"/> Spermatorrhea	<input type="checkbox"/> Testicular Pain/Swelling	
<input type="checkbox"/> Low Sperm Count	<input type="checkbox"/> Testicular Cancer	

**Musculoskeletal** (check all that apply)

<input type="checkbox"/> Neck/Shoulder Pain	<input type="checkbox"/> Muscle Spasms/Cramps	<input type="checkbox"/> Joint Pain (specify where):
<input type="checkbox"/> Low Back Pain	<input type="checkbox"/> Leg Pain	_____
<input type="checkbox"/> Upper Back Pain	<input type="checkbox"/> Restless Leg Syndrome	
<input type="checkbox"/> Mid Back Pain	<input type="checkbox"/> Arm Pain	

**Neurologic** (check all that apply)

<input type="checkbox"/> Vertigo/Dizziness	<input type="checkbox"/> Loss of Balance	<input type="checkbox"/> Poor Memory
<input type="checkbox"/> Paralysis	<input type="checkbox"/> Seizures/Epilepsy	<input type="checkbox"/> Tremors
<input type="checkbox"/> Numbness/Tingling	<input type="checkbox"/> Brain Tumor	<input type="checkbox"/> Other:

**Endocrine** (check all that apply)

<input type="checkbox"/> Hypothyroid	<input type="checkbox"/> Hypoglycemia	<input type="checkbox"/> Night Sweats
<input type="checkbox"/> Hyperthyroid	<input type="checkbox"/> Diabetes Mellitus	<input type="checkbox"/> Feeling Hot or Cold