Acupuncture with Cadance: Health History & Questionnaire

***(Please bring completed form to your initial appointment*)**

Today's Date: _____

Name (first, middle and last): _____

Date of Birth: _____ Age: _____ Gender: _____

Street Address: _____ City: _____

State: _____ Zip: _____ Email: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Occupation: _____

Is it acceptable to leave you a message and if so at which phone/email? _____

Emergency Contact: _____ Phone: _____

❑Married ❑Partnered ❑Single ❑Widowed ❑Divorced Name of Spouse: _____

Referred by _____ ❑Friend/family ❑Website Other:_____

Primary Care Physician: _____ Physician's Phone: _____

I. **Major Symptoms:** Please list in order of importance what conditions/symptoms are of concern to you.
(most concerning to least along with duration of symptom)

1. _____

2. _____

3. _____

What medical diagnoses and treatments have you received for these conditions?

_____

_____

II. Medical History

Please circle all that apply	***Date diagnosed***		***Date diagnosed***
Diabetes	_____	Bleeding Disorder	_____
High Blood Pressure	_____	Thyroid Disease	_____
Seizures	_____	Cancer	_____
Hepatitis (type_____)	_____	Pacemaker	_____
Heart Disease	_____	Anti-coagulant medication	_____

III. Allergies (to medications, chemicals, foods, metals, etc.)

_____

_____

IV. YOUR HEALTH: **CHECK ALL THAT APPLY**

GENERAL

Past	*Current*	*Condition*
[ ]	[ ]	Poor appetite
[ ]	[ ]	Excessive appetite
[ ]	[ ]	Change in appetite
[ ]	[ ]	Insomnia
[ ]	[ ]	Fatigue
[ ]	[ ]	Night sweats
[ ]	[ ]	Sweat easily
[ ]	[ ]	Catch cold easily
[ ]	[ ]	Strong thirst
[ ]	[ ]	Other:

MUSCULAR-SKELETAL

Past	*Current*	*Condition*
[ ]	[ ]	Back/shoulder/neck pain
[ ]	[ ]	Sore, cold or weak knees
[ ]	[ ]	Muscle spasm, twitching
[ ]	[ ]	Joint pain
[ ]	[ ]	Arthritis
[ ]	[ ]	Artificial joint
[ ]	[ ]	Other:

HEAD & NECK

Past	*Current*	*Condition*
[ ]	[ ]	Dizziness
[ ]	[ ]	Fainting
[ ]	[ ]	Headaches
[ ]	[ ]	Hair loss
[ ]	[ ]	Enlarged lymph glands
[ ]	[ ]	Other:

EARS, NOSE, THROAT

Past	*Current*	*Condition*
[ ]	[ ]	Ear infection
[ ]	[ ]	Ear ringing
[ ]	[ ]	Decreased hearing
[ ]	[ ]	Sinus infection
[ ]	[ ]	Hay fever or allergies
[ ]	[ ]	Difficulty swallowing
[ ]	[ ]	Enlarged lymph glands
[ ]	[ ]	Reduced sense of smell
[ ]	[ ]	Nose bleeds
[ ]	[ ]	Other:

EYES

Past	*Current*	*Condition*
[ ]	[ ]	Blurred vision
[ ]	[ ]	Vision changes
[ ]	[ ]	Dry or itchy eyes
[ ]	[ ]	Red eyes
[ ]	[ ]	Other:

CARDIOVASCULAR

Past	*Current*	*Condition*
[ ]	[ ]	High blood pressure
[ ]	[ ]	Low blood pressure
[ ]	[ ]	Palpitations
[ ]	[ ]	Blood clots
[ ]	[ ]	Chest pain
[ ]	[ ]	Irregular heart beat
[ ]	[ ]	Difficult breathing
[ ]	[ ]	Swelling hands/feet
[ ]	[ ]	Cold hands/feet
[ ]	[ ]	Heart disease
[ ]	[ ]	Bleeding disorder
[ ]	[ ]	Anti-coagulant medication
[ ]	[ ]	Other:

RESPIRATORY

Past	*Current*	*Condition*
[ ]	[ ]	Asthma
[ ]	[ ]	Bronchitis
[ ]	[ ]	COPD/Chronic obstructive
[ ]	[ ]	Pulmonary disease
[ ]	[ ]	Pneumonia
[ ]	[ ]	Coughing blood
[ ]	[ ]	Production of phlegm
[ ]	[ ]	Other:

GASTRO-INTESTINAL

Past	*Current*	*Condition*
[ ]	[ ]	Nausea
[ ]	[ ]	Vomiting
[ ]	[ ]	Diarrhea
[ ]	[ ]	Constipation
[ ]	[ ]	Blood in stools
[ ]	[ ]	Hemorrhoids
[ ]	[ ]	Abdominal pain or cramps
[ ]	[ ]	Acid reflux/GERD
[ ]	[ ]	Other:

GENITO-URINARY

Past	*Current*	*Condition*
[ ]	[ ]	Painful urination
[ ]	[ ]	Frequent urination
[ ]	[ ]	Blood in urine
[ ]	[ ]	Urgency to urinate
[ ]	[ ]	Unable to hold urine
[ ]	[ ]	Kidney stones
[ ]	[ ]	Other:

NEUROLOGICAL

Past	*Current*	*Condition*
[ ]	[ ]	Seizures
[ ]	[ ]	Tremors
[ ]	[ ]	Numbness/tingling of limbs
[ ]	[ ]	Paralysis
[ ]	[ ]	Memory difficulties
[ ]	[ ]	Other:

SKIN & HAIR

Past	*Current*	*Condition*
[ ]	[ ]	Rashes or Hives
[ ]	[ ]	Itching
[ ]	[ ]	Eczema
[ ]	[ ]	Psoriasis
[ ]	[ ]	Dryness
[ ]	[ ]	Fungal infection
[ ]	[ ]	Acne
[ ]	[ ]	Tumors, lumps
[ ]	[ ]	Other:

PSYCHOLOGICAL

Past	*Current*	*Condition*
[ ]	[ ]	Depression
[ ]	[ ]	Anxiety/stress
[ ]	[ ]	Irritability
[ ]	[ ]	Other:

INFECTION SCREENING

Past	*Current*	*Condition*
[ ]	[ ]	HIV
[ ]	[ ]	Hepatitis (type:)
[ ]	[ ]	TB
[ ]	[ ]	Fungal infection
[ ]	[ ]	Gonorrhea
[ ]	[ ]	Chlamydia
[ ]	[ ]	Syphilis
[ ]	[ ]	Genital warts
[ ]	[ ]	Herpes: oral
[ ]	[ ]	Herpes: genital
[ ]	[ ]	Other:

FEMALE

Past	*Current*	*Condition*
[ ]	[ ]	Pregnancy
[ ]	[ ]	Infertility
[ ]	[ ]	Pelvic inflammatory disease
[ ]	[ ]	Endometriosis
[ ]	[ ]	Hysterectomy
[ ]	[ ]	Frequent vaginal infections
[ ]	[ ]	Pain/itching of genitalia
[ ]	[ ]	Irregular menstrual periods
[ ]	[ ]	Painful menstrual periods
[ ]	[ ]	PMS
[ ]	[ ]	Abnormal bleeding
[ ]	[ ]	Perimenopausal syndrome
[ ]	[ ]	Other:

MALE

Past	*Current*	*Condition*
[ ]	[ ]	Pain/itching genitals
[ ]	[ ]	Erectile dysfunction
[ ]	[ ]	Weak urine stream
[ ]	[ ]	Prostate problem
[ ]	[ ]	Lumps in testicles
[ ]	[ ]	Other:

V. Surgical/Serious Illness History

_____ Date _____

_____ Date _____

_____ Date _____

VI. Medications/Supplements

List medications and food supplements you are taking (including both prescription and over the counter medicines you take on a regular basis, along with dosages and brands if known)

_____

_____

_____

VII. Social History

1. Do you exercise regularly? ❑Yes ❑No

   If yes, how many times per week: ___ Activities: _____

2. How much per day do you use the following?

   a) Coffee, tea, soft drinks: _____

   b) Alcohol: _____

   c) Cigarettes, cigars, other tobacco: _____

3. Do you follow a special diet? ❑Yes ❑No If yes, how would you describe the diet (ie. vegetarian, low carb, gluten free, etc)? _____

VIII. Family History

List family (grandparent , mother, father, sibling, or child) history of disease such as heart disease, cancer, hypertension, stroke, asthma, allergies, migraines, depression, substance abuse, osteoporosis, diabetes, glaucoma, etc.

_____

_____

_____

Signature
The information on this form is correct to the best of my knowledge. Signature _____ Date _____