Thank you for your interest in the Kicotan Acupuncture & Holistic Healing clinic.

Please be so kind to complete this entire health history form to the best of your ability. All information obtained in this historic document can be extremely helpful to assist you in realizing your optimal health and wellness goals.

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| **PATIENT INFORMATION** | | | | | | |
| Today’s Date: | | | | Gender: Click or tap here to enter text. | | |
| Patient’s Last Name: First Name: Middle Name  Click or tap here to enter text. | | | | | Preferred Name: | |
| Alias Maiden Name: Click or tap here to enter text. | | | | | Social Security #  Click or tap here to enter text. | |
| Street Address: Click or tap here to enter text. | | | | | Date of Birth:  Click or tap here to enter text. | |
| City: Click or tap here to enter text. | State: Click or tap here to enter text. | | | | | Zip code:  Click or tap here to enter text. |
| Home Phone:  Click or tap here to enter text. | Cell Phone:  )Click or tap here to enter text. | | May KAHH calls and leave a Message:  Yes  No | | | |
| Other Phone:  Click or tap here to enter text. | Email Address:  Click or tap here to enter text. | | May KAHH sends you emails about events or newsletters:  Yes  No | | | |
| Marital Status: Single  Married Divorced  Widowed  Domestic Partner  Other | | | | | | |
| Spouse/Domestic Partner’s Name: Click or tap here to enter text. | | | | | | |
| **EMERGENCY CONTACT** | | | | | | |
| Emergency Contact:  Click or tap here to enter text. | | Relationship:  Click or tap here to enter text. | | | | |
| Emergency Contact Phone #:  Click or tap here to enter text. | | Emergency Contact Office/Cell Number:  Click or tap here to enter text. | | | | |
| **PRIMARY CARE PROVIDER** | | | | | | |
| Provider’s Name:  Click or tap here to enter text. | | Provider’s Office Phone #  Click or tap here to enter text. | | | | |
| Provider’s Address:  Click or tap here to enter text. | | Date of Last Visit:  Click or tap here to enter text. | | | | |
| If you do not have a Primary Care Provider, are you interested in establishing Primary Care? | | | | | | |

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| **EMPLOYMENT** | |
| I am currently:  Full-time Part-Time Self-Employed  Student Unemployed  Retired | |
| Job Title Description: Click or tap here to enter text. | |
| Employer’s Name: Click or tap here to enter text. | Employer’s Phone:  Click or tap here to enter text. |

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| **GENERAL HEALTH** |
| Chief Complaint: What is the primary concern associated with your visit today?  Click or tap here to enter text. |
| Onset: How long have you had this/these issues?  Click or tap here to enter text. |
| Does anything make the condition better? Yes  No If yes, what?Click or tap here to enter text. |
| Have you been treated for this condition before?  Yes  No If yes, please describe:  Click or tap here to enter text. |
| Are you currently being treated for other medical problems? Yes  No If yes, please describe  Click or tap here to enter text. |
| Are there any other issues or health concerns you are hoping to work on?  Click or tap here to enter text. |
| Have you tried Acupuncture before?  Click or tap here to enter text. |
| How did you hear about the Kicotan Acupuncture & Holistic Healing Center?  Website  Another Health Care Provider  Advertisement  Friend  Other |

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| **MEDICATIONS** | | | | | |
| Do you have any allergies to medications? Yes No  If yes, please describe: | | | | | |
| List Pharmaceuticals, both prescriptions and over the counter medications you are currently taking: | | | | | |
| List all herbal prescriptions and supplements you are taking? | | | | | |
| **DIET AND NUTRITION**-Please describe a typical daily diet in your life. | | | | | |
| Breakfast: | | | | | |
| Lunch: | | | | | |
| Dinner: | | | | | |
| Snack: | | | | | |
| **RISK FACTOR SCREENING** | | | | | |
| Please describe your past and current usage of the following substances: | | | | | |
| **Past** | **Curren**t |  |  |  | Comments |
|  |  | Caffeine |  | Cups Per Day |  |
|  |  | Tobacco |  | Cigarettes per day/week |  |
|  |  | Alcohol |  | Drinks per day/week |  |
|  |  | Crack |  | Use per day/week |  |
|  |  | Meth |  | Use per day/week |  |
|  |  | Heroin |  | Use per day/week |  |
|  |  | Other |  | Use per day/week |  |

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| **SIGNS AND SYMPTOMS** | | | | |
| Check the “*past*” box next to any symptoms you have experienced in the past. Check the “*current*” box next to any symptoms you are currently experiencing. | | | | |
| **General:**  Past Current  Insomnia  Dreams and Nightmares  Cold hands/feet  Chills  Fever  Night Sweats  Decreased ability to taste or smell  Sweet taste in the mouth  Metallic taste in the mouth  Crave for spicey foods  Crave for sweet foods  Crave for sour foods  Crave for bitter foods  Often feels sad  Often feels afraid  Often feels angry  Usually feels happy  Irritability  Depression  Anxiety  Mood Swings  Fatigue  Often worried  Indecisiveness  Poor Memory  **Neurological**  Past Current  Seizures  Tremors  Numbness and tingling  Paralysis  Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | **Head and Neck:**  Past Current  Headaches  Migraines  Stiff neck  Dizziness  Fainting  Swollen Glands  Other\_\_\_\_\_\_  **Eyes**  Past Current  Corrective  Lenses  Blurred Vision  Poor night vision  Spots or Floaters  Inflammation  Dryness  Tearing  Glaucoma  Other\_\_\_\_\_\_\_\_\_\_\_\_  **Ears**  Past Current  Ear Ringing  Hearing Loss  Infections  Earache  Vertigo  Other\_\_\_\_\_\_\_\_\_\_\_\_ | | **Nose, Throat, Mouth:**  Past Current  Sinus infections  Allergies  Dry Throat  The feeling of something stuck in the throat  Sore throat  Difficulty Swallowing  Grinding teeth  Nasal congestion  Nose Bleeds  Loss of voice  Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Respiratory**  Past Current  Difficulty Breathing with exertion  Difficulty breathing when lying down.  Wheezing  Asthma  Chronic cough  Cough with Phlegm  Cough with Blood  Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **SIGNS AND SYMPTOMS** | | | | |
| Check the “past” box next to any symptoms you have experienced in the past. Check the “current” box next to any symptoms you are currently experiencing. | | | | |
| **Cardiovascular**  Past Current  High Blood Pressure  Low Blood Pressure  Chest Pain or tightness  Palpitations  Rapid Heartbeat  Poor circulation  Swollen Ankles  Anemia  Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Gastrointestinal**  Past Current  Nausea  Vomiting  Acid Reflux/GERD  Stomach Pain  Abdominal bloating  Indigestion  Poor Appetite  Change in appetite  Gas: Belching  Gas: Flatulence  Diarrhea  Constipation  Dry/ Hard Stools  Blood in stools  Hemorrhoids  Jaundice  Liver Disorder  Gallbladder Disorder  Other\_\_\_\_\_\_\_\_\_\_\_\_\_ | **Skin**  Past Current  Hives  Rashes  Eczema  Psoriasis  Dry Skin  Easy Bruising  Changes in moles  Itching  Measles  Chicken Pox  Shingles  Acne  Other\_\_\_\_\_\_\_\_\_\_\_\_\_  **Musculoskeletal**  Past Current  Joint Pain  Weak Muscles  Sore/Weak Knees/Ankle  Difficulty walking  Neck/Shoulder pain  Upper/ Mid Back Pain  Lower Back Pain  Limited Range of Motion  Rib Pain  Muscle spasms/ twitch  Other\_\_\_\_\_\_\_\_\_\_\_\_ | | **Genito-Urinary**  Past Current  Frequency urination  Painful urination  Urgent Urination  Blood in the urine  Unable to hold urine  Incomplete urination  Wake to urine  Kidney Stones  Increase sex drive  Decrease sex drive  Pain/Itching of genitalia  Genital lesions/discharge  Infertility  Other\_\_\_\_\_\_\_\_\_\_\_\_\_  **Female Specific**  Past Current  Frequent urinary tract infections.  Frequent vaginal infections  Pelvic Inflammatory Dis.  Premenstrual syndrome  Abnormal PAP smear  Irregular Periods  Painful menstrual bleeding  Abnormal bleeding  Menopause symptoms  Breast Lumps  Other\_\_\_\_\_\_\_\_\_\_\_\_ | |

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| **SIGNS AND SYMPTOMS** |
| Check the “past” box next to any symptoms you have experienced in the past. Check the ‘current” box next to any symptoms you are currently experiencing. |
| **Male Specific**  Past Current  Premature ejaculation  Testicular lumps  Prostatitis  Impotence  Other  **Infection Screening**  Past Current  Check  if you have been tested, circle positive (+) if you have been the condition).  HIV (+)  TB (+)  Hepatitis A/B/C (+)  HPV (+)  Gonorrhea (+)  Chlamydia (+)  Syphilis (+)  Genital Warts (+)  Herpes oral/genitals (+) |

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| **FEMALE REPRODUCTIVE HEALTH** | | | | | | | |
| Age of first menstruation: | | First day of last menses: | | Duration of flow (#of days): | | | Clots: (Yes or No) |
| Color of Blood: | | Number of Days in cycle: (21, 28, 33, etc) | | | Consistency (Thin or thick) | | |
| PMS:  Pain  Cramps | |  | | |  | | |
| Current method of Contraception: | | | | Contraceptive History: | | | |
| Have you ever been pregnant?  Yes  No | | Are you trying to get Pregnant?  Yes  No | | Are you currently Pregnant?  Yes  No | | Due Date: | |
| Date of Menopause: | | Hormone Replacement Therapy:  yes  No | | I understand that I must notify my acupuncturist or health Practitioner if I become pregnant\_\_\_\_\_\_\_\_\_\_\_\_ (initial and date) | | |

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| **SEXUAL ACTIVITY** | | |
| Are you sexual activity?  Yes  No | Number of current of recent sexual partners | Do you currently practice safe sex?  Yes  No |

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| **PRIOR HOSPITALIZATION OR SURGERIES** | |
| Year: | Operation/Condition |
| Year: | Operation/Condition |
| Year: | Operation/Condition |

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| **ADDITIONAL INFORMATION** |
| Do you currently have an exercise regiment?  Yes  No If yes, please describe |
| Do you have a spiritual practice?  Yes  No If yes, please describe |
| Please describe any additional information about yourself or the condition not covered by the above question. |