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 NameClick 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 describeClick 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[ ]  [ ]  CorrectiveLenses[ ]  [ ]  Blurred Vision[ ]  [ ]  Poor night vision[ ]  [ ]  Spots or FloatersInflammation[ ]  [ ]  Dryness[ ]  [ ]  Tearing[ ]  [ ]  GlaucomaOther\_\_\_\_\_\_\_\_\_\_\_\_**Ears**Past Current[ ]  [ ]  Ear Ringing[ ]  [ ]  Hearing Loss[ ]  [ ]  Infections [ ]  [ ]  Earache[ ]  [ ]  VertigoOther\_\_\_\_\_\_\_\_\_\_\_\_  | **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 voiceOther\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Respiratory**Past Current[ ]  [ ] Difficulty Breathing with exertion[ ]  [ ]  Difficulty breathing when lying down. [ ]  [ ]  Wheezing[ ]  [ ]  Asthma[ ]  [ ]  Chronic cough[ ]  [ ]  Cough with Phlegm[ ]  [ ]  Cough with BloodOther\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **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[ ]  [ ]  AnemiaOther\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**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.  |