

MINSTER ACUPUNCTURE STUDY

HEALTH HISTORY

Date: ___ / ___ / ___

Name: _____		Sex: _____	Age: _____
Address: _____		City: _____	State: _____
Phone #1: Home Cell Other	Phone #2: Work Cell Other	Email: _____	Zip Code: _____
Date of Birth: _____	Emergency Contact: (name & relationship)	Phone #: _____	
Height: _____	Weight: _____	Relationship Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Separated	
Occupation: _____		<input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Living w/partner <input type="checkbox"/> Other: _____	
How did you hear of our clinic? <input checked="" type="checkbox"/> Craigslist <input checked="" type="checkbox"/> Flyer <input checked="" type="checkbox"/> Walk / Drive by <input checked="" type="checkbox"/> Print Ad <input checked="" type="checkbox"/> Other: _____		Referred by: _____	
Physician: _____	Phone #: _____	Have you been treated by Acupuncture or Oriental Medicine Before? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes ___ / ___ / ___	

MAIN COMPLAINTS

Please write in your top 3 health complaints / concerns in order of importance to you. Circle the items that make it better or worse and mark on the scale from 1-10 the severity of the condition (1=no symptoms, 10=worst ever)

1 ↔

When did this start? _____ ago

Heat makes it better no change worse

Cold makes it better no change worse

Damp weather: better no change worse

Exercise / Activity: better no change worse

1 _____ 10

2

When did this start? _____ ago

Heat makes it better no change worse

Cold makes it better no change worse

Damp weather: better no change worse

Exercise / Activity: better no change worse

1 _____ 10

3

When did this start? _____ ago

Heat makes it better no change worse

Cold makes it better no change worse

Damp weather: better no change worse

Exercise / Activity: better no change worse

1 _____ 10

HEALTH HISTORY

Circle the **↓** if you have / had the condition and note the year it started.
 Circle the **☑** if there is a family history of the condition.

Cancer type(s)? <input type="checkbox"/> Diabetes <input type="checkbox"/> Hepatitis <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Heart Disease <input type="checkbox"/> Stroke <input type="checkbox"/> Seizure Disorder <input type="checkbox"/> Thyroid Disease <input type="checkbox"/> Asthma <input type="checkbox"/> Pacemaker <input type="checkbox"/>	Osteoporosis <input type="checkbox"/> Herpes <input type="checkbox"/> AIDS / HIV <input type="checkbox"/> Other STD <input type="checkbox"/> Rheumatic Fever <input type="checkbox"/> Alcoholism <input type="checkbox"/> Allergies type(s)? <input type="checkbox"/> Mental Illness <input type="checkbox"/> Kidney Disease <input type="checkbox"/> Anemia <input type="checkbox"/>
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YOU Year FAMILY YOU Year FAMILY

HABITS

Amount / Week If Quit Year?

Coffee / Tea _____

Soda _____

Tobacco _____

Alcohol _____

Drugs _____

EXERCISE

Do you exercise regularly? Yes No

If so, what and how often: _____

DIET Do you have a special diet now or in the past? (vegetarian, vegan, raw, Atkins, etc.)
 Describe w/ dates: _____

MEDICATIONS

Please note what medications, herbs or supplements that you take regularly

INJURIES & SURGERIES

Please note what happened to what body area and when it occurred (incl. dental)
