HEALING JOURNEY
ACUPUNCTURE AND WELLNESS

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Phone: 610-996-3740 **Fax:** 1-877-377-0020

Health History Form

First Name: **Last Name:** **Gender:**

Home Phone: **Mobile Phone:**

Street Address:

City: **State:** **Zip:**

Emergency Contact: **Phone:**

Primary Care Provider: **Phone:**

Name of referring professional: **Phone:**

Date of Birth/Age:

Occupation:

Main health issues you wish to address:
____
____
____
____
____

Please tell us about these conditions: ____
____
____
____
____

How long have you had these conditions?:

What seems to make it better?:

What seems to make it worse?:

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Patient Name: ______________________________

Are you under the care of a physician?:

If so, what are you being seen for?:

Please describe any dietary restrictions:

____
____
____

Please describe any allergies you may have (medications, foods, environmental etc.):

____
____
____
____

Recent significant life events:

____
____
____

Rate on a scale of 1-10
Sleep: _______
Digestion: _______
Energy Level: _______
Appetite: _______

In general, I feel my health is:
☐ Excellent ☐ Good ☐ Fair ☐ Poor

Elimination regular?:
☐ Yes ☐ No

Please check any conditions that apply to you:

☐ Faints easily ☐ Needle phobic ☐ Pregnancy ☐ Using blood thinners ☐ HIV/AIDS ☐ Hepatitis B/C

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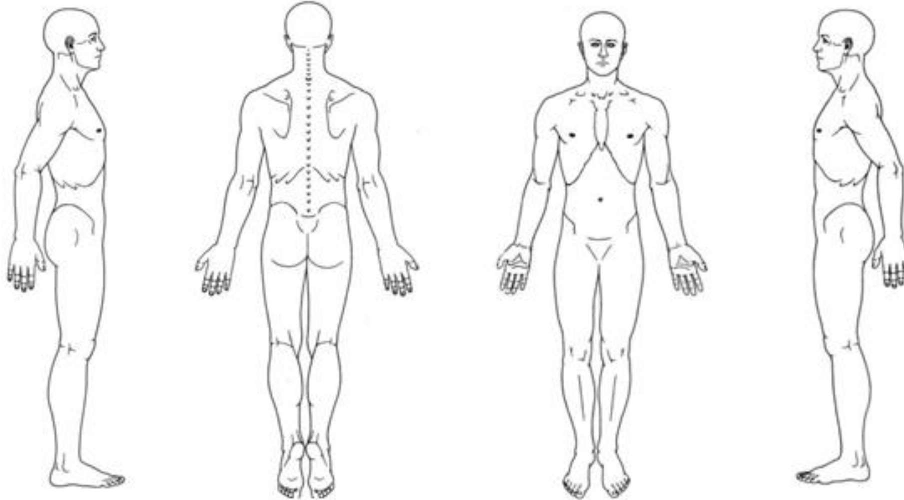
Patient Name: ______________________________

Please indicate any areas of pain or injury on this diagram.



Type of pain: ☐ Dull ☐ Sharp ☐ Stabbing ☐ Throbbing ☐ Cramping

☐ Burning ☐ Limited Range of Motion ☐ Limited Use

Description of Pain and Injury Symptoms/Areas Affected:

____

____

____

____

____

____

Accidents/Surgeries (please list with approximate date):

____

____

____

____

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Patient Name: ______________________________

Energy and Temperature:

- ☐ High Energy
- ☐ Low Energy
- ☐ Energy Fluctuates
- ☐ Always tired
- ☐ Hot Body Temp
- ☐ Cold Body Temp
- ☐ Poor Circulation

Sleep:

- ☐ Difficult to fall asleep
- ☐ Difficult to stay asleep
- ☐ Wakes frequently
- ☐ Night sweats
- ☐ Disturbing dreams
- ☐ Insomnia
- ☐ Wakes to urinate multiple times per night

Digestion:

- ☐ Loose stools
- ☐ Constipation
- ☐ Gas
- ☐ Abdominal pain
- ☐ Cravings: ____________________
- ☐ Bloating
- ☐ No appetite
- ☐ Hungry all the time
- ☐ Other: ____________________ ____________________

Miscellaneous:

- ☐ Alcohol/Substance Dependency
- ☐ Blurry Vision
- ☐ Bruises Easily
- ☐ Chronic Low Back Pain
- ☐ Dizziness
- ☐ Floaters in Field of Vision
- ☐ Headaches
- ☐ Hemorrhoids
- ☐ Memory Problems
- ☐ Mental Chatter
- ☐ Poor Night Vision
- ☐ Respiratory Illness
- ☐ Ringing in Ears
- ☐ Varicose Veins

Prescription Medications and Non-Prescription Medications (please list):

____
____
____
____
____

Supplements and Herbs (please list):

____
____
____
____
____

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Patient Name: ______________________________

Female Health

Menstrual Cycle

Since Age: _______ Number of days in cycle: __________ Number of days in menses: _________

☐ Regular
☐ Irregular
☐ Light red
☐ Dark red
☐ Brownish

☐ Moodiness
☐ Clots
☐ PMS
☐ Breast distension
☐ Bloating

☐ Menopause
If so, no menses since: ________________
Experiences/symptoms during menopause: _______________
____
☐ Other: ____

Female History: Mark '1' if current, '2' if past

1 ☐ **2** ☐ Ablation
1 ☐ **2** ☐ Breast implants
1 ☐ **2** ☐ Breast lumps
1 ☐ **2** ☐ Breast reconstruction
1 ☐ **2** ☐ D & C
1 ☐ **2** ☐ Pain during ovulation
1 ☐ **2** ☐ Yeast infections
1 ☐ **2** ☐ Irregular bleeding
1 ☐ **2** ☐ Irregular PAP

1 ☐ **2** ☐ Interstitial Cystitis
1 ☐ **2** ☐ Fibroids
1 ☐ **2** ☐ Fibrocystic breasts
1 ☐ **2** ☐ Hysterectomy
1 ☐ **2** ☐ Mastectomy
1 ☐ **2** ☐ Lumpectomy
1 ☐ **2** ☐ Dryness with intercourse
1 ☐ **2** ☐ Pain with intercourse
1 ☐ **2** ☐ Tubal Ligation

1 ☐ **2** ☐ Vaginal discharge:
Color ______________
Frequency __________
Amount _____________

Date of last PAP smear:
____
Results:
____

Pregnancy/Birth Control

Are you pregnant now? ☐ Yes ☐ No
If so, how many weeks? __________
Number of pregnancies: __________
Number of children: _____________
Dates of births: _________________

Birth control method(s): __________________________
Previous: ☐ Miscarriages? ☐ Terminations?
☐ Ectopic pregnancies?
Difficulty in conceiving?: _______________

Other Comments:

____
____
____