ALIGN ACUPUNCTURE AND HERBS LLC
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Patient Information and Health History

Date:_____________

Name:____ Date of Birth:____________________

Street:____

City:_____________________________ State:____________ Zip:________________________

Phone: (H)____________________ (W)_____________________ ©)_____________________

Please use my (H) ___ (W)___ ©)____ as my primary contact number

Email address:____

Emergency contact:____ Phone:________________

Physician:____Phone:________________

Main Condition(s) for which you are seeking treatment with history: when did it start? How often does it bother you? Does it interfere with activities of daily life (sleep, work, recreation)?

1)____

2)____

3)____

Current Medications: list prescription and over-the-counter medications and supplements

____

____

____

Medication and/or food allergies or sensitivities:____

____

Past Medical History: list surgeries, hospitalizations, chronic conditions, traumatic accidents

____

____

____

Lifestyle
Do you exercise regularly? ____

Do you use tobacco? ____

Do you consume alcohol on a weekly basis?____

Do you consume caffeine on a daily basis?____

Do you drink diet soda or use artificial sweeteners on a daily basis?___________________________

Are you on a restricted diet?____

____

Physiological Functions

Energy: overall energy level (1-10) _____/10

Fatigue: (circle all that apply) AM PM After Work After Meals Better w/Exercise
Worse w/ Damp Heat Cold

Sleep: Average hours per night________ Do you have trouble falling asleep? _________
Do you have trouble staying asleep?_____________

Thirst: How much do you drink/day?_____________ Do you feel thirsty?___________

Appetite: Low So-So Good Too Good
Do you crave a particular flavor? Salty Sweet Sour Spicy Greasy

Perceived Temperature: Do you tend to be warmer or cooler then the people around you?
Do you feel hot at night?__________ Do you have cold hands and/or feet?________

Sweat: Do you sweat w/out exertion?__________ Night sweats?_____________________

How often do you catch a cold or feel sick? ____

Skin: Dryness Rashes Eczema Spider Veins Scars Acne Moles

Head: Foggy Headed Dizziness Poor Concentration/Memory

Headaches: Frequency?_____________ Duration?_________________Intensity?____________

Are your headaches often located in the same area of the head?__________________

What is the quality of the headache? Dull Throbbing Stabbing Tight

Do you experience visual changes, nausea, or environmental sensitivity with a headache?

Please describe____

What triggers your headache?____

What makes your headache better?____

Eyes: Dryness Itching Burning Tearing Floaters Blurry Vision Poor Night Vision

Ears: Ringing Deafness Blocked

Nose: Sinusitis Rhinitis Post Nasal Drip Nosebleeds Sinus Pressure

Mouth: Canker Sores Sores on Lips Gum Pain/Bleeding Burning Sensation in Tongue

Throat: Difficult Swallowing Swollen Glands Frequent Sore Throat Loss of Voice

Chest: Pain Tightness Heavy Feeling Palpitations Rib Pain Coughing

History of Asthma?_____________ TB?_________ COPD?_________

Stomach: Bloating Gas Nausea Heart Burn Reflux

Bowel Movements: times/day or week?__________________

Pain Blood Hard to Pass Loose Hard Pellet Like Incomplete Feeling

Hemorrhoids Mucus

Urination: times/day?______________ Do you need to get up at night to urinate? ____________

History of urinary tract infections?____

GYN: Age at 1st Period? _____________ Date of last period?______________

Pregnancies______________ Miscarriages_______________ Abortions______________

Are you pregnant now?____

Length of menstrual cycle?_____________ Number of days of bleeding?____________

Peri Menopausal Symptoms?____

PMS: Irritability Weepiness Moodiness Cramping Bloating Change in Bowels
Back Pain Breast Tenderness Headache

History of Yeast Infections?____________________ STDs?_____________________________

Sexual Energy: Interest (1-10)?_____________ Problems with arousal?____________________

Muscular/Skeletal: Areas of pain or numbness?______________________________________

____

____

Quality of pain: Stabbing Burning Throbbing Dull Constant Intermittent
Does pain wake you at night or prevent you from falling asleep?____________________
What reduces your pain?____

Emotions: How would you describe yourself emotionally?_______________________________

____

Stress Level (1-10): Job?___________ Family?____________Money?_____________
Do you feel overwhelmed?____
Do you feel supported by friends and family?_____________________________
Have you experienced major losses in the last year(death of a loved one or pet, divorce, loss of a job)?____

____

Have you ever been treated for depression or anxiety?____________________________

Do you have any implanted medical devices (pacemaker, insulin pump, replaced joints....)?____

____

Are there other concerns that you would like to discuss or things that you feel we should know about you?____

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