**Patient Information & Health History Robin Arnold, MS, AP, L. Ac., CFMP, Dipl. Ac**(NCCAOM®)

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City:\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_ Zip:\_\_\_\_\_\_\_\_\_\_

Phones: Cell:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_; Other (indicate Home/Work): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Would you like to receive health newsletters from this office? \_\_\_\_Yes \_\_\_\_No

Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Referred by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Sex: \_\_\_Male \_\_\_\_Female Birthdate:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_\_\_\_ Dominant Hand: \_\_\_L \_\_\_R

Emergency Contact:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever had acupuncture before?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ if yes, When? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Last Physical Exam by Medical Doctor \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Last Blood/Lab Work\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you currently under the care of an M.D. for any medical condition?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please describe condition(s) for which treatment is sought:**

**Chief complaint**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of onset of symptoms:\_\_\_\_\_\_\_\_\_\_\_\_ Severity of symptoms1-10 (1 mild/ 10 severe) \_\_\_\_\_\_\_\_\_\_ \_

Have you seen your physician about this condition?\_\_\_\_\_\_\_ other treatments\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Secondary complaint**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of onset of symptoms:\_\_\_\_\_\_\_\_\_\_\_\_ Severity of symptoms1-10 (1 mild/ 10 severe) \_\_\_\_\_\_\_\_\_\_ \_\_

Have you seen your physician about this condition?\_\_\_\_\_\_\_ other treatments\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Additional complaint** (if any): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of onset of symptoms:\_\_\_\_\_\_\_\_\_\_\_\_ Severity of symptoms1-10 (1 mild/ 10 severe) \_\_\_\_\_\_\_\_\_\_ \_

Have you seen your physician about this condition?\_\_\_\_\_\_\_ other treatments\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please indicate if any of the following apply to you:**

Hemophiliac: \_\_\_Yes \_\_\_No Epilepsy: \_\_\_Yes \_\_\_No Pacemaker: \_\_\_Yes \_\_\_No

Anticoagulant use: \_\_\_Yes \_\_\_No Heart Condition: \_\_\_Yes \_\_\_No Vegetarian: \_\_\_Yes \_\_\_No

Lung Condition: \_\_\_Yes \_\_\_No Diabetes: \_\_\_Yes \_\_\_No Stroke: \_\_\_Yes \_\_\_No

Hepatitis: \_\_\_Yes \_\_\_No HIV/AIDS: \_\_\_Yes \_\_\_No Cancer: \_\_\_Yes \_\_\_No

Are you pregnant/ is there a chance that you are pregnant? \_\_\_Yes \_\_\_No

\*Note: you must advise if and when you are pregnant.

\*Note: you must advise if there is any change in your medical conditions.

**Please list the medications and supplements you are currently taking:**

Drug/Supplement Reason for Taking For How Long Dose Frequency

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Lifestyle:**

**Exercise:** please check what applies:

\_\_\_\_Mostly Sedentary (little to no activity) \_\_\_\_\_\_Mild Exercise (housework, gardening, etc.)

\_\_\_\_Occasional vigorous exercise (under 4x/week for 30 mins. each)

\_\_\_\_Regular vigorous exercise (over 4x/week for 30 mins. each/ hard manual labor)

\_\_\_\_Extreme exercise (professional athlete, serious amateur athlete, 6-7x/week over 45 minutes each session)

**Diet/Intake:**

# of meals eaten in average day \_\_\_\_\_\_\_\_ Estimated glasses of water per day\_\_\_\_\_\_

Coffee cups per day: \_\_\_\_\_\_ Tea cups/glasses per day: \_\_\_\_\_\_\_ Soda cans/glasses per day: \_\_\_\_\_\_\_\_\_

Food Cravings or excesses (i.e. sugar, cheese): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How often do you eat vegetables: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Alcohol type/amount per week: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Tobacco per week: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Would you like to improve your health with nutritional guidance? \_\_\_\_\_\_

Are you willing to implement changes? \_\_\_\_\_\_\_

**How do you feel about the following areas of your life in the past month?**

Self: \_\_\_\_Great \_\_\_Good \_\_\_Fair \_\_\_Poor \_\_\_N/A Comments: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Family: \_\_\_\_Great \_\_\_Good \_\_\_Fair \_\_\_Poor \_\_\_N/A Comments:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Significant Other: \_\_\_Great \_\_\_Good \_\_\_Fair \_\_\_Poor \_\_\_N/A Comments:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Work: \_\_\_\_Great \_\_\_\_Good \_\_\_\_Fair \_\_\_\_Poor \_\_\_\_N/A Comments:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How would you rate your current stress level? \_\_\_Extreme \_\_\_Very High \_\_\_High \_\_\_Moderate \_\_\_Low

Does this fluctuate? \_\_\_\_Yes \_\_\_\_No Why?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How would you rate your current energy level? \_\_\_Very High \_\_\_High \_\_\_Moderate \_\_\_Low \_\_\_\_Very Low

Does this fluctuate? \_\_\_\_Yes \_\_\_\_No Why?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Other Symptoms:**

***\*\*Please Circle/ indicate if you regularly experience any of the following:***

**Head & Neck:** Dizziness Fainting Stiff Neck Headache Migraine Enlarged Lymph Nodes

Other or explanation:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Eyes & Ears:** Blurred Vision Red/Burning/Itching Eyes Spots/Floaters Dry Eyes Excess Tearing Poor Night Vision

Vertigo Ear ache Decreased Hearing Ringing in Ears Chronic Ear Infection

Other or explanation:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Respiratory/Nose:**  Cough Coughing up Blood Cough with Phlegm Difficulty Breathing Bronchitis

Wheezing/Asthma Allergies Frequent Colds Chronic Sinus Infection Nasal Congestion Nosebleeds

Other or explanation:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Genital/Urinary:** Pain/Itching of Genitalia Frequent Urination Urgent or Unable to Hold Urination Bedwetting

Painful/Burning Urination Excessive or Scant Urination Blood in Urine Kidney Stone Increased or Decreased Libido

Other or explanation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Cardiovascular:**  Heart Palpitations Chest Pain/Tightness Poor Circulation Varicose Veins

Irregular heartbeat Swelling of Feet/Ankles

Other or explanation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Gastrointestinal:** Nausea Vomiting Gas Hiccups Bloating Bad Breath Acid Reflux/Heartburn

Rectal pain/itchiness Constipation or Hard Stool Loose Stool IBS/Alternating Constipation/Diarrhea Hemorrhoids Intestinal Pain/Cramping Laxative Use Blood in Stool Mucous in Stool Black Stool

Other or explanation:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Appetite/Thirst:** Excessive Hunger Poor Appetite Hunger w/no desire to eat Specific Cravings

Excessive Thirst Thirst w/no desire to drink No Thirst

Temperature of drinks most commonly desired: Very Cold Room Temp. Hot

Other or explanation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Mouth & Throat**: Bleeding Gums Recurrent Sore Throat Bitter Taste in Mouth Dry Mouth

Tongue/Mouth Sores/Ulcers Difficulty Swallowing Lump in Throat Hoarseness or Loss of Voice

Other or explanation:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Skin:** Hives/Rashes Acne Dry Skin Eczema/Psoriasis Itchy Skin Easily Bruised

Brittle/Weak Nails Spontaneous Sweating Night Sweating

Other or explanation:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Muscles & Joints:**  Joint Swelling Joint Pain Joint Discoloration Location:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Body Ache/Stiffness General Weakness Numbness/Tingling \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Heaviness of body/ limbs

Other or explanation:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Sleep:** Sound/Restful Trouble Falling Asleep Awaken During the Night (what time?)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Vivid Dreaming/Nightmares Difficulty Waking Up Wake Easily/Early

Other or explanation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Emotions:** Relaxed/Calm Sad/Grief/Depressed Fearful Anxious Angry/Frustrated Worry

Trouble with Decision Making Forgetful/Poor Memory Impatient Stressed Manic

Other or explanation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**General:**  Cold Hands/Feet Always Feel Hot Always Feel Cold Fever & Chills

Recent Unexplained Weight Changes Fatigue Edema

Other or explanation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Women – Menses:** Regular Irregular Menopause Date/Year of last period\_\_\_\_\_\_\_\_\_\_\_\_\_

Amenorrhea (absence of) Dysmenorrhea (painful periods) Excessive Flow Scanty Flow

Clots Mid-cycle Spotting Cramping PMS Vaginal Discharge

Oral Contraceptive Use Hysterectomy Endometriosis Fibroids

Other or explanation:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Pregnant: \_\_\_\_yes \_\_\_\_no \_\_\_\_\_maybe \_\_\_\_\_trying !!(advise if any changes)!!

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**Please answer if you have pain:**

Location of Pain:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_For How Long? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any known cause? (i.e.: injury) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Quality of Pain: \_\_\_Dull \_\_\_Sharp \_\_\_Stabbing \_\_\_Sore \_\_\_Cramping \_\_\_Burning \_\_\_Constant

\_\_\_Fixed \_\_\_Moves Does Pain Radiate?\_\_\_\_\_\_ Where\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Level of Pain: (on a scale of 1 – 10: 1 = very low; 10 = unbearable) \_\_\_\_\_\_\_\_\_\_\_\_\_

What aggravates the pain? \_\_\_Ice \_\_\_ Heat \_\_\_ Rest \_\_\_Movement \_\_\_Pressure \_\_\_Moisture \_\_\_Massage \_\_\_\_Nothing

What helps the pain? \_\_\_Ice \_\_\_ Heat \_\_\_ Rest \_\_\_Movement \_\_\_Pressure \_\_\_Moisture \_\_\_Massage \_\_\_\_Nothing

When is the pain the worst? \_\_\_Morning\_\_\_Afternoon\_\_\_Evening

**I will update my practitioner of any changes to my history, information and conditions with future consults and/or treatments.**

Patient signature Date