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## NEW PATIENT HEALTH HISTORY

Thank you for your interest in acupuncture and Chinese herbal medicines. Please complete this health history. All the information obtained in this history will help us assess you today and assist you in attaining your optimal health and wellness

PATIENT INFORMATION			
Today's Date:		Gender:	Date of Birth:
Patient's Last Name		First Name:	Middle/ Initial:
Street Address			
City:		State:	ZIP Code:
Home Phone (    )	Work Phone:(    )	Cell Phone: (    )	
Email Address:		May we send you emails about ALC events and ALC newsletters?    Yes <input type="checkbox"/> No <input type="checkbox"/>	
Are you: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Domestic partnership <input type="checkbox"/> Other			
Spouse/Partners Name:			
Name(s) of Children:			
Referred by:	Height:	Weight:	Weight one year ago:
EMERGENCY CONTACT			
Emergency Contact:		Relationship:	
Emergency Contact Phone: (    )			
PRIMARY CARE PROVIDER			
Provider's Name:		Provider's Phone: (    )	
Provider's Address		Date of Last Visit:	
If you do not have a primary care provider, are you interested in establishing primary care?			
INSURANCE PROVIDER INFORMATION			
Name of Health Insurance Provider		Type of Plan:	
ID#:	Group No.:		
EMPLOYMENT			
I am currently: <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Self Employed <input type="checkbox"/> Student <input type="checkbox"/> Unemployed <input type="checkbox"/> Retired			
Job Title/Description		Number of hours of work/study per week:	
Employer's Name:		Employer's Phone: (    )	
Employer's Address:			
GENERAL HEALTH			
<b>Chief Complaint:</b> What is the primary concern for your visit today?			
Onset: How long have you had this/these issues?			
Does anything make the condition better? If Yes, what?			
Does anything make the condition worse? If Yes, what?			
Have you been treated for this condition before?    Yes <input type="checkbox"/> No <input type="checkbox"/> If Yes, please describe:			
Are you currently being treated for this or other medical problems? Yes <input type="checkbox"/> No <input type="checkbox"/> If Yes, please describe:			
Are there any other issues or health concerns you are hoping to work on?			
Have you been treated with acupuncture before?			
How did you hear about us?			
FAMILY MEDICAL HISTORY (Please specify family member)			
<input type="checkbox"/> Cancer	_____	<input type="checkbox"/> Stroke	_____
<input type="checkbox"/> Hepatitis	_____	<input type="checkbox"/> Hypertension	_____
<input type="checkbox"/> Heart Disease	_____	<input type="checkbox"/> Alcoholism	_____
<input type="checkbox"/> Asthma	_____	<input type="checkbox"/> Mental Illness	_____
<input type="checkbox"/> Diabetes	_____	<input type="checkbox"/> Other	_____

**CURRENT/PAST MEDICAL HISTORY**

Check any conditions that you are currently experiencing or have had in the past:

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Alcoholism           | <input type="checkbox"/> Epilepsy/ Seizures | <input type="checkbox"/> Mental Illness   |
| <input type="checkbox"/> Anemia               | <input type="checkbox"/> Glaucoma           | <input type="checkbox"/> Migraines        |
| <input type="checkbox"/> Arthritis            | <input type="checkbox"/> Headache           | <input type="checkbox"/> Nervous Disorder |
| <input type="checkbox"/> Asthma               | <input type="checkbox"/> Heart Disease      | <input type="checkbox"/> Pneumonia        |
| <input type="checkbox"/> Auto Immune Disorder | <input type="checkbox"/> Hepatitis          | <input type="checkbox"/> Profuse Bleeding |
| <input type="checkbox"/> Blood Transfusion    | <input type="checkbox"/> HIV                | <input type="checkbox"/> Stroke           |
| <input type="checkbox"/> Breathing Problems   | <input type="checkbox"/> Hypertension       | <input type="checkbox"/> Thyroid Disorder |
| <input type="checkbox"/> Cancer               | <input type="checkbox"/> Jaundice           | <input type="checkbox"/> Tuberculosis     |
| <input type="checkbox"/> Diabetes             | <input type="checkbox"/> Kidney Disease     | <input type="checkbox"/> Vein condition   |
| <input type="checkbox"/> Digestive Disorder   | <input type="checkbox"/> Liver Disease      | <input type="checkbox"/> Veneral Disease  |

Other Conditions:

Known allergies (food, airborne, drug, other):

Have you received allergy shots or other allergy treatment? Please describe:

Significant trauma (accident, injury):

Immunizations:

Hospitalizations &amp; Surgery:

Major Dental Procedures (silver fillings/mercury amalgams?):

Do you have a history of frequent antibiotic use? Please describe:

**LIFESTYLE: DIET, EXERCISE, RISK FACTORS**Do you exercise?  Yes  No What kind? How often?Do you travel frequently?  Yes  NoHave you traveled overseas/ to any 'developing' countries? Yes  No Do you have an active or sedentary job?  Active  Sedentary

How many hours do you sleep at night? When do you go to bed?

Please describe your daily meals:

Breakfast Lunch Dinner

Soft drinks per day Cups of coffee per day Glasses of water per day

Are you a vegetarian or vegan?

Do you use:  Tobacco How often: \_\_\_\_\_

Alcohol \_\_\_\_\_

Caffeine \_\_\_\_\_

Marijuana \_\_\_\_\_

Other 'recreational' drugs \_\_\_\_\_

**MEDICATIONS**

Do you have allergies to any medications? If so, please describe:

List Pharmaceuticals, prescription and over-the-counter, that you are currently taking:

List herbal supplements and herbal formulas/prescriptions you are currently taking:

**PROFILE****Body Temperature**

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Hot body temperature  | <input type="checkbox"/> Palms, hands, feet sweat | <input type="checkbox"/> Profuse sweating    |
| <input type="checkbox"/> Cold body temperature | <input type="checkbox"/> Afternoon flushing       | <input type="checkbox"/> Lack of sweating    |
| <input type="checkbox"/> Cold hands, cold feet | <input type="checkbox"/> Hot flashes              | <input type="checkbox"/> Strong thirst       |
| <input type="checkbox"/> Perspire easily       | <input type="checkbox"/> Night sweats             | <input type="checkbox"/> Little or no thirst |

**General**

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Insomnia                   | <input type="checkbox"/> Usually feel happy | <input type="checkbox"/> Decreased smell         |
| <input type="checkbox"/> Nightmares/excess dreaming | <input type="checkbox"/> Often feel sad     | <input type="checkbox"/> Decreased taste         |
| <input type="checkbox"/> Chills                     | <input type="checkbox"/> Often feel afraid  | <input type="checkbox"/> Sweet taste in mouth    |
| <input type="checkbox"/> Fevers                     | <input type="checkbox"/> Often feel angry   | <input type="checkbox"/> Metallic taste in mouth |
| <input type="checkbox"/> Numbness/tingling          | <input type="checkbox"/> Irritability       | <input type="checkbox"/> Crave spicy foods       |
| <input type="checkbox"/> Dizziness                  | <input type="checkbox"/> Mood swings        | <input type="checkbox"/> Crave sweet foods       |
| <input type="checkbox"/> Fainting                   | <input type="checkbox"/> Depression         | <input type="checkbox"/> Crave salty foods       |
| <input type="checkbox"/> Anxiety                    | <input type="checkbox"/> Worry              | <input type="checkbox"/> Crave sour foods        |
| <input type="checkbox"/> Poor memory                | <input type="checkbox"/> Indecisiveness     | <input type="checkbox"/> Crave bitter foods      |

<b>Overall Energy</b>			
<input type="checkbox"/>	Adequate/ good energy	<input type="checkbox"/>	Easily fatigued
<input type="checkbox"/>	Sleep well/ wake up refreshed	<input type="checkbox"/>	Frequent illnesses, colds, flu, etc.
<b>Head and Neck</b>			
<input type="checkbox"/>	Headaches	<input type="checkbox"/>	Disc herniation
<input type="checkbox"/>	Migraines	<input type="checkbox"/>	Disc degeneration
<input type="checkbox"/>		<input type="checkbox"/>	Stiff neck
<input type="checkbox"/>		<input type="checkbox"/>	Frozen shoulder
<b>Eyes</b>			
<input type="checkbox"/>	Glasses/corrective lenses	<input type="checkbox"/>	Blurred vision
<input type="checkbox"/>	Spots or floaters	<input type="checkbox"/>	Dryness, Itchiness
<input type="checkbox"/>	Inflammation	<input type="checkbox"/>	Glaucoma
<input type="checkbox"/>		<input type="checkbox"/>	Poor night vision
<input type="checkbox"/>		<input type="checkbox"/>	Tearing
<input type="checkbox"/>		<input type="checkbox"/>	Catarracts
<b>Ears</b>			
<input type="checkbox"/>	Ear ringing	<input type="checkbox"/>	Hearing Loss
<input type="checkbox"/>	Dizziness/vertigo	<input type="checkbox"/>	Other _____
<input type="checkbox"/>		<input type="checkbox"/>	Ear Infections
<b>Nose, throat, mouth</b>			
<input type="checkbox"/>	Allergies	<input type="checkbox"/>	Nasal Congestion
<input type="checkbox"/>	Sinus infection	<input type="checkbox"/>	Nosebleeds
<input type="checkbox"/>	Dry throat	<input type="checkbox"/>	Difficulty swallowing
<input type="checkbox"/>	Sore throat	<input type="checkbox"/>	Loss of voice
<input type="checkbox"/>	Feeling of something stuck in throat	<input type="checkbox"/>	Bad breath
<input type="checkbox"/>		<input type="checkbox"/>	Bleeding gums
<input type="checkbox"/>		<input type="checkbox"/>	Grinding teeth
<input type="checkbox"/>		<input type="checkbox"/>	Jaw clicking
<b>Musculoskeletal</b>			
<input type="checkbox"/>	Muscle spasms	<input type="checkbox"/>	Neck/shoulder pain
<input type="checkbox"/>	Limited range of motion	<input type="checkbox"/>	Upper/ mid back pain
<input type="checkbox"/>	Difficulty walking	<input type="checkbox"/>	Lower back pain
<input type="checkbox"/>	Pain in extremities	<input type="checkbox"/>	Sore or weak knees/ankles
<input type="checkbox"/>	Carpal tunnel	<input type="checkbox"/>	Arthritis
<input type="checkbox"/>	Tendonitis	<input type="checkbox"/>	Disc degeneration/herniation
<input type="checkbox"/>		<input type="checkbox"/>	Rib pain
<input type="checkbox"/>		<input type="checkbox"/>	Joint pain
<input type="checkbox"/>		<input type="checkbox"/>	Weak muscles
<input type="checkbox"/>		<input type="checkbox"/>	Broken bones
<input type="checkbox"/>		<input type="checkbox"/>	Rheumatoid Arthritis
<input type="checkbox"/>		<input type="checkbox"/>	Plantar fasciitis
<b>Blood Function</b>			
<input type="checkbox"/>	Dizziness	<input type="checkbox"/>	Blurry vision
<input type="checkbox"/>	Tingling in extremities	<input type="checkbox"/>	Poor night vision
<input type="checkbox"/>	Forgetfulness	<input type="checkbox"/>	Floaters
<input type="checkbox"/>	Difficulty concentrating	<input type="checkbox"/>	Tinnitus
<input type="checkbox"/>		<input type="checkbox"/>	Dryness, itchiness
<input type="checkbox"/>		<input type="checkbox"/>	Scanty menses
<input type="checkbox"/>		<input type="checkbox"/>	Weak nails
<input type="checkbox"/>		<input type="checkbox"/>	Fainting
<b>Skin</b>			
<input type="checkbox"/>	Rashes	<input type="checkbox"/>	Psoriasis
<input type="checkbox"/>	Hives	<input type="checkbox"/>	Rosacea
<input type="checkbox"/>	Eczema	<input type="checkbox"/>	Dry/flaky skin
<input type="checkbox"/>		<input type="checkbox"/>	Changes in moles
<input type="checkbox"/>		<input type="checkbox"/>	Acne
<input type="checkbox"/>		<input type="checkbox"/>	Shingles
<b>Lung/Respiratory Function</b>			
<input type="checkbox"/>	Difficulty breathing with exertion	<input type="checkbox"/>	Chronic allergies
<input type="checkbox"/>	Difficulty breathing lying down	<input type="checkbox"/>	Wheezing
<input type="checkbox"/>	Persistent cough	<input type="checkbox"/>	Asthma
<input type="checkbox"/>	Sinus congestion	<input type="checkbox"/>	Chronic cough
<input type="checkbox"/>	Nasal dryness	<input type="checkbox"/>	Wet/dry cough
<input type="checkbox"/>		<input type="checkbox"/>	Dry or flaky skin
<input type="checkbox"/>		<input type="checkbox"/>	Sneezing
<input type="checkbox"/>		<input type="checkbox"/>	Chest tightness
<b>Heart/Cardiovascular Function</b>			
<input type="checkbox"/>	High blood pressure	<input type="checkbox"/>	Irregular heart beat
<input type="checkbox"/>	Low blood pressure	<input type="checkbox"/>	Poor circulation
<input type="checkbox"/>	Chest pain or tightness	<input type="checkbox"/>	Swollen ankles
<input type="checkbox"/>	Palpitations	<input type="checkbox"/>	Anemia
<input type="checkbox"/>	Rapid heart beat	<input type="checkbox"/>	Insomnia
<input type="checkbox"/>		<input type="checkbox"/>	Tongue ulcers
<input type="checkbox"/>		<input type="checkbox"/>	Speech impediment
<input type="checkbox"/>		<input type="checkbox"/>	Severe shyness
<input type="checkbox"/>		<input type="checkbox"/>	Mental restlessness
<input type="checkbox"/>		<input type="checkbox"/>	Restless dreams
<b>Spleen Function</b>			
<input type="checkbox"/>	Indigestion	<input type="checkbox"/>	Weight gain
<input type="checkbox"/>	Gas	<input type="checkbox"/>	Weight loss
<input type="checkbox"/>	Bloating	<input type="checkbox"/>	Poor appetite
<input type="checkbox"/>	Fatigue following meal	<input type="checkbox"/>	Gurgling in intestines
<input type="checkbox"/>		<input type="checkbox"/>	Hypoglycemia
<input type="checkbox"/>		<input type="checkbox"/>	Strong cravings
<input type="checkbox"/>		<input type="checkbox"/>	Bruise easily
<input type="checkbox"/>		<input type="checkbox"/>	Hemorrhoids
<b>Stomach Function</b>			
<input type="checkbox"/>	Stomach pain	<input type="checkbox"/>	Nausea
<input type="checkbox"/>	Acid Reflux	<input type="checkbox"/>	Vomiting
<input type="checkbox"/>	Bad breath	<input type="checkbox"/>	Excess appetite
<input type="checkbox"/>		<input type="checkbox"/>	Belching
<input type="checkbox"/>		<input type="checkbox"/>	Flatulence
<input type="checkbox"/>		<input type="checkbox"/>	Change in appetite

<b>Bowel Function</b>			
<input type="checkbox"/> Loose stool/diarrhea	<input type="checkbox"/> Stool hard/small/dry	<input type="checkbox"/> Incomplete evacuation	
<input type="checkbox"/> Constipation	<input type="checkbox"/> Blood in stools	Number of bowel	
<input type="checkbox"/> Mucous in stools	<input type="checkbox"/> Difficulty moving bowel	movements per day?	
<b>Accumulated Dampness</b>			
<input type="checkbox"/> Swollen hands	<input type="checkbox"/> Mental fogginess	<input type="checkbox"/> Edema/legs	
<input type="checkbox"/> Swollen feet	<input type="checkbox"/> Poor mental focus	<input type="checkbox"/> Edema/abdomen	
<input type="checkbox"/> Joint stiffness	<input type="checkbox"/> General feeling of sluggishness	<input type="checkbox"/> Chest congestion	
<b>Liver/Gall Bladder Function</b>			
<input type="checkbox"/> Liver disorder	<input type="checkbox"/> Headache/Migraine	<input type="checkbox"/> Easily angered	
<input type="checkbox"/> Gall bladder disorder	<input type="checkbox"/> Hypochondriac pain	<input type="checkbox"/> Easily stressed	
<input type="checkbox"/> Gallstones	<input type="checkbox"/> Chronic neck/shoulder tension	<input type="checkbox"/> Irritability	
<input type="checkbox"/> Jaundice	<input type="checkbox"/> Muscle cramps/spasms	<input type="checkbox"/> Depression	
<b>Kidney/Bladder - Genito/Urinary Function</b>			
<input type="checkbox"/> Frequent urination	<input type="checkbox"/> Strong odor	<input type="checkbox"/> Frequent cavities	
<input type="checkbox"/> Painful/burning urination	<input type="checkbox"/> Night-time urination	<input type="checkbox"/> Broken/loose teeth	
<input type="checkbox"/> Urgent urination	<input type="checkbox"/> Difficulty initiating	<input type="checkbox"/> Hearing loss	
<input type="checkbox"/> Blood in urine	<input type="checkbox"/> Bedwetting	<input type="checkbox"/> Premature graying of hair	
<input type="checkbox"/> Incontinence	<input type="checkbox"/> Kidney stone	<input type="checkbox"/> Hair loss	
<input type="checkbox"/> Incomplete urination	<input type="checkbox"/> Pain/itching genitals	<input type="checkbox"/> Ringing in ears	
<input type="checkbox"/> Clear urine	<input type="checkbox"/> Weak bones	<input type="checkbox"/> Genital lesions	
<input type="checkbox"/> Cloudy urine	<input type="checkbox"/> Osteopenia/Osteoporosis	<input type="checkbox"/> Increased sex drive	
<input type="checkbox"/> Yellow/dark urine	<input type="checkbox"/> Weak, sore knees	<input type="checkbox"/> Decreased sex drive	
<input type="checkbox"/> Large amount	<input type="checkbox"/> Low back pain	<input type="checkbox"/> Vaginal discharge	
<input type="checkbox"/> Dribbling	<input type="checkbox"/> Cold low back/hips/knees	<input type="checkbox"/> Vaginal itching	
<b>Male Specific</b>			
<input type="checkbox"/> Prostatitis	<input type="checkbox"/> Premature ejaculation	<input type="checkbox"/> Impotence	
<input type="checkbox"/> Painful/swollen testicles	<input type="checkbox"/> Difficulty maintaining erection	<input type="checkbox"/> Infertility	
<b>Female Specific</b>			
<input type="checkbox"/> Irregular periods	<input type="checkbox"/> UTI	<input type="checkbox"/> Vaginal infections	
<input type="checkbox"/> Painful menstruation	<input type="checkbox"/> Pelvic infection/ PID	<input type="checkbox"/> Vaginal discharge	
<input type="checkbox"/> Scanty/ heavy bleeding	<input type="checkbox"/> Fibroids	<input type="checkbox"/> Candida	
<input type="checkbox"/> Clots	<input type="checkbox"/> Ovarian cysts	<input type="checkbox"/> Fertility issues	
<input type="checkbox"/> Breast tenderness	<input type="checkbox"/> Abnormal PAP smear	<input type="checkbox"/> Menopausal issues	
<input type="checkbox"/> Breast lumps	<input type="checkbox"/> Endometriosis		
<input type="checkbox"/> PMS: please describe: _____			
Age of first menstruation: _____ First day of last menses: _____			
Duration of flow/number of days: _____ Number of days in cycle: _____			
Current method of contraception: _____ Contraception history: _____			
Have you ever been pregnant? _____ Are you trying to get pregnant? _____ Are you currently pregnant? _____			
Number of pregnancies: _____ Due date: _____			
Number of children: _____ Number of births: _____			
Premature births _____ Miscarriages _____ Abortions _____ Cesareans _____			
I understand that I must inform my acupuncture practitioner if/when I become pregnant. _____ (initial &			
Date of menopause: _____ Signs/symptoms: _____ Hormone Replacement Therapy? _____			
<b>ASSIGNMENT and RELEASE</b>			
I have read and understand my chiropractic/physical therapy benefits as explained to me. I also understand that this is strictly an estimate and not a guarantee of payment according to my insurance company. I authorize payment of medical benefits to Austin Longevity Center and the release of medical records or other information necessary for the processing of my claims.			
I understand that this office will bill my insurance company as a courtesy to me, and if for any reason the insurance company does not pay or cover the services that I will be directly responsible for all charges. I also understand that any appointment without a prior 24 hour notice is subject to a fee of \$25. I authorize the use of this signature on all insurance submissions.			
Patient's Signature: _____ Date: _____			