new life acupuncture clinic

HEALTH HISTORY FORM

Date	Address
Name	City, State, Zip
Preferred Name	Date of Birth, Age
Preferred Pronouns	Height, Weight
Assigned Sex at Birth (circle) F / M	Marital/Partnership Status
Gender Identity (circle) Cis / Trans / Non-binary / Gender non-conforming	
Email	Profession
Phone	Referred By
Can we leave a detailed message at this number? Yes / No	
Emergency Contact Name and Phone	
Have you been treated by Acupuncture or Oriental Medicine before? Yes / No	

Main Problem(s):
When did this problem begin? (be specific)
How much does this problem interfere with your daily activities? (work, sleep, etc.)
What, if any, diagnoses have you been given for this problem?
What treatments have you tried? What makes it better or worse?
What does it feel like? (circle all that apply) Dull / sharp / burning / aching / throbbing / numbness / tingling / tension / other _____
Are you seeing any other medical professionals for this issue? If yes, what kind and who?

Name: _____ Date of Birth: _____

Check any symptoms you've experienced in the last three months.

General		Ears, Eyes, Nose, Throat		Respiratory		Gastrointestinal	
Fever		Earaches		Cough		Nausea	
Chills		Sinus problems		Bronchitis		Vomiting	
Bleed or bruise easily		Poor hearing		Pneumonia		Constipation	
Peculiar taste or smell		Cataracts		Asthma		Diarrhea	
Strong thirst		Facial pain		Tuberculosis		Chronic laxative use	
No desire to drink		Poor vision		Pain with deep breath		Gas	
Sudden energy drop Time of day?		Ringing in ears (tinnitus)		Difficult breathing when lying down		Abdominal pain or cramps	
Fatigue		Eye strain		Production of phlegm		Bad breath	
Poor sleep		Night blindness		Coughing blood		Belching	
Night sweats		Blurry vision		When was your last cold or flu?		Burning sensation	
Sweat easily		Spots in front of eyes				Indigestion	
Cravings		Eye pain		Other		Blood in stools	
Change in appetite		Color blindness				Rectal pain or burning	
Poor appetite		Nose bleeds		**Cardiovascular**		Anal prolapse	
Weight gain		Recurrent sore throats		High blood pressure		Hemorrhoids	
Weight loss		Sores on lips or tongue		Low blood pressure		Other	
Skin and Hair		Grinding teeth		Irregular heartbeat			
Hives		Teeth problems		Blood clots		**Genito-urinary**	
Rashes		Jaw clicks		Dizziness		Painful urination	
Itching		Other		Cold hands or feet		Urinary urgency	
Dandruff				Swelling of hands		Frequent urination	
Ulcerations		**Musculoskeletal**		Swelling of feet		Urinary incontinence	
Eczema		Muscle pain		Phlebitis		Blood in urine	
Hair loss		Muscle weakness		Chest pain		Kidney stones	
Acne		Neck pain		Fainting		Sores on genitals	
Recent moles		Back pain		Near fainting		Impotency	
Change in hair or skin		Hip pain		Difficult breathing		Waking to urinate	
Other		Other		Other		Urine color	
						Other	

Name: _____ Date of Birth: _____

Neuropsychological				Gynecology			
Concussions		Poor balance		Painful periods		Age of 1st menses	
Migraines		Lack of coordination		Vaginal discharge		Cycle length (avg 28 days)	
Headaches		Depression		Color?		Duration of menses (avg 4-7 days)	
When and where?		Difficulty concentrating		Changes in body/psyche prior to menstruation		1st day of last menses	
		Easily stressed		Clots		Heavy bleeding	
Poor memory		Bad temper		Vaginal sores		Light bleeding	
Seizures		Anxiety		Irregular periods		# of pregnancies	
Stroke		PTSD		Breast lumps		# of births	
Tremors		Other		Fibroid cysts		# premature births	
Numbness				Date of last Pap		# miscarriages	
Concussion				History of abnormal Pap		# abortions	
Dizziness				Date of last mammogram		Are you sexually active?	Y / N
Vertigo				History of abnormal mammogram		Do you use birth control? Y / N What type and how long?	
				Other			

Past Personal and Family Medical History (if checked for self, please add date/year)

	Self	Family		Self	Family		Self	Family
Alcoholism			Depression			POTS		
Allergies			EDS			Rheumatic fever		
Arthritis			Emphysema			Seizures		
Asthma			Glaucoma			STI		
Blood Disorder			Heart Disease			Stroke		
Blood Pressure High / Low			Hepatitis			Tuberculosis		
Cancer (type?)			HIV/AIDs			Thyroid Disease		
CRPS			Kidney Disease			Other		
Diabetes			Lupus					

Name: _____ Date of Birth: _____

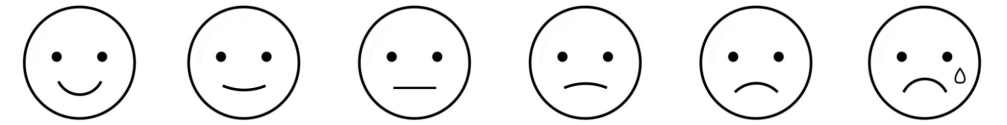
Surgeries (type and date)
Significant Physical Trauma (auto accidents, falls, etc)
Significant Dental Work (type and date)
Allergies (drugs, chemicals, food/result)
Ongoing stressors
Do you have a regular exercise program? If yes, please describe
Are you/have you been on a restricted diet? If yes, please describe
Do you smoke cigarettes? Yes / No / Quit If yes, how many cigarettes do you smoke per day? _____ Do you use other forms of nicotine? (Vaping, chew, snuff, etc) If yes, please specify type and amount.
How many caffeinated beverages do you drink per day? (Coffee, soda, energy drinks, etc)
How many alcoholic drinks do you consume per week? Beer _____ Wine _____ Liquor _____
Do you use recreational drugs? (Ex. Cannabis, kratum, medicinal mushrooms) If yes, please describe type and method of consumption

Medicines/Supplements taken within the last two months

Name of medicine/supplement	Reason for taking it
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

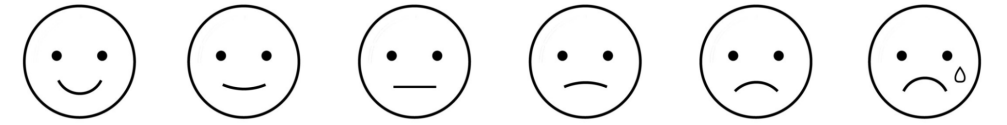
Name: _____ Date of Birth: _____

Please note the severity of your main problem now:



0 1 2 3 4 5 6 7 8 9 10

Please note the average severity of your main problem within the last week:

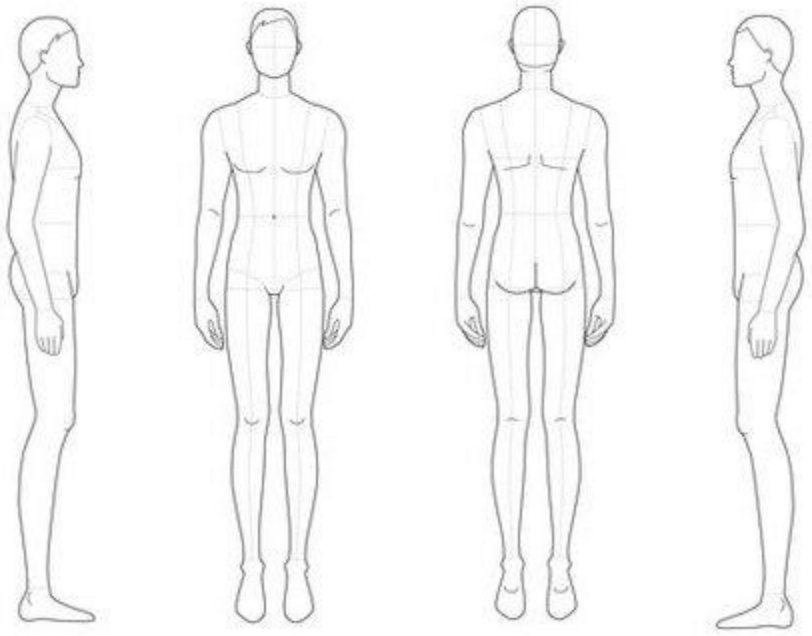


0 1 2 3 4 5 6 7 8 9 10

0 = no interference with daily life, ability and enjoyment
3 = interferes some with daily life but more of a background annoyance that's manageable
5 = consistently an issue, impaired daily activities but mostly able to work around it
7 = overwhelming interference with daily life, basics are very difficult to manage
10 = unrelenting interference with daily life, basics are unmanageable

Please indicate painful or distressed areas:

x - pain o - tension // - numbness/tingling



Name: _____ Date of Birth: _____

Patient-Specific Functional Scale

0 1 2 3 4 5 6 7 8 9 10

Unable to perform activity

Able to perform activity at the same level as before problem

Score⤵

Activity **Date →**	Ex: 9/1					
1.						
2.						
3.						
4.						
5.						
6.						
Example: Standing	Ex: 4					

Comments (any other problems or concerns you'd like to discuss)

_____

_____

_____

_____

_____

_____

_____

Name: _____ Date of Birth: _____