Health History Information

All information is treated as confidential unless you grant permission to release it. Please print and complete all information.

Name:____ Date:______________

Date of Birth:_______________________ M / F Age:______________

Address:____ City:_____________________ State:__________ Zip:___________

Day Phone:_____________________ Evening Phone:_________________________ Fax:______________________________

Email:____

Emergency Contact Information:(Name, Phone Number and Relationship)____

Occupation:___________________________ Employer's Name/Address:____

____

Referred by:____

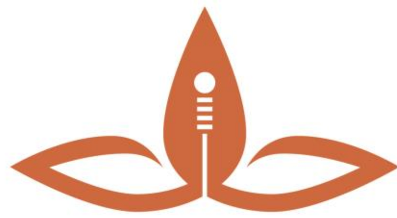
Are you currently under the supervision of a medical doctor? Yes / No

Physician's Name & Phone Number:____

Reason for today's visit:____

Is this your first acupuncture treatment? Yes / No

Family History	IF LIVING		IF DECEASED	
		HEALTH	DEATH AGE	CAUSE OF DEATH
	AGE	Good Fair Poor		
Father				
Mother				
Sibling (Circle Sex)				
1. M F				
2. M F				
3. M F				
4. M F				
5. M F				
Husband ☐ Wife ☐				
Children (Circle Sex)				
1. M F				
2. M F				
3. M F				
4. M F				
5. M F				
6. M F				



Thrive iwc

Any blood relatives who have or have had any of the listed conditions?							
	Yes	No	Relationship		Yes	No	Relationship
Asthma				Hay Fever			
Arthritis				Kidney Disease			
Allergies				Leukemia			
Anemia				Mental Disorders			
Alcoholism				Migraine			
Bleeding Tend.				Nervous Breakdown			
Cancer				Obesity			
Colitis				Rheumatism			
Congenital Heart				Rheumatic Fever			
Diabetes				Stroke			
Epilepsy				Suicide			
Goiter				Stomach Ulcers			
High Bl. Press.				Tuberculosis			
Heart Disease				Other (please list)			

HABITS Daily Consumption
Do you smoke? Y / N ______ Pkgs.
Drink Coffee? Y / N ______ Cups
Drink Alcohol? Y / N ______ oz.
Fall Asleep Easily? Y / N
Awaken Early? Y / N

PLEASE LIST ANY MEDICATIONS AND /OR SUPPLEMENTS YOU ARE CURRENTLY TAKING?____
____
____
____

Operations you have had: Year
____
____

Diseases you have had requiring hospitalization: Year
____
____

Serious Illness Not requiring hospitalization: Year
____
____

Drugs you are allergic to:____________________________________
____

Describe any serious injuries or accidents you have had:____
____
____

WOMEN ONLY - Please check all that apply: Are you still having regular monthly periods? Y / N

Bleeding between periods? ڤ
Discharge? ڤ
Heavy Bleeding? ڤ
Bloating? ڤ Gas? ڤ
Pain? ڤ Headaches? ڤ
Low Back Pain? ڤ
Cramping? ڤ

Depression? ڤ
Irritability? ڤ
Taken Birth Control Pills? ڤ
How long? ______________
Miscarriage? ڤ How Many?_________
No. of children born alive?__________
No. of stillbirths? ________

Complications with pregnancy? ڤ
Length of Menstrual Cycle? ______ Days
How many days flow? ______
Clotting? ڤ
Dark purple blood? ڤ
Brownish Blood? ڤ

Are you or do you suspect that you might be pregnant now? Yes / No If yes, how many months? __________

MEN ONLY – Please check all that apply:

Loss of sexual activity? ڤ
Discharge from penis? ڤ
Treatment for genitals? ڤ
Hernia (rupture)? ڤ
Prostate trouble? ڤ

MEN AND WOMEN – Please check all that apply:

Headaches? ڤ
Dizziness? ڤ
Ringing in the ears? ڤ
Convulsions? ڤ
Blurred vision? ڤ
Coughing / Wheezing? ڤ
Stuffy/Runny Nose? ڤ
Acid Reflux / Heartburn? ڤ
Bad taste in mouth? ڤ
Loss of appetite? ڤ
Bleeding gums? ڤ
Sore throat? ڤ
Sweating other than with exertion? ڤ

Chest tightness? ڤ
Shortness of Breath? ڤ
Palpitations (feeling heartbeat?) ڤ
Pain in calves when walking? ڤ
Tingling in legs at night? ڤ
Trouble sleeping? ڤ
Anxiety-filled dreams? ڤ
Difficult or frequent urination? ڤ
Blood in urine? ڤ
Kidney stones? ڤ
Pain in abdomen? ڤ
Constipation? ڤ
Diarrhea? ڤ

Undigested food in stool? ڤ
Mucous in stool? ڤ
Fatigue? ڤ
Excessive Thirst? ڤ
Low Thirst? ڤ
Excessive Appetite? ڤ
Low Appetite? ڤ
Recent Weight Gain? ڤ
Recent Weight Loss? ڤ
Low Back Pain? ڤ
Knee Pain? ڤ
Cold Hands & Feet? ڤ
Numbness? Where?___________

Do you exercise regularly? Y / N How often (Hours/Days per week)____________
What type of exercise do you perform? ____
Please describe any injuries: