Woodbury Family Chiropractic
Custom Adjustments. Amazing Results

Acupuncture Patient Health History

Name: _____ Date: _____/_____/_____
(first) (middle) (last)

Date of Birth: _____/_____/_____ Age: _____ Sex: Gender: Marital status: S M D W

Reason for Visit (Main Complaint):

Successful health care and preventative medicine are only possible when the practitioner has a complete understanding of the patient physically, mentally and emotionally. Please complete this questionnaire as thoroughly as possible. Print all information and indicate areas of confusion with a question mark. Thank you.

Have you seen a healthcare provider for your main compaint today? If so, what kinds of care have you received?

Please identify any other health concerns that you have, in order of importance below:

Condition **Past Treatment**

a. _____ _____

How does this condition affect you? _____

b. _____ _____

How does this condition affect you? _____

c. _____ _____

How does this condition affect you? _____

d. _____ _____

How does this condition affect you? _____

Do you have any reason to believe you are, or may be, pregnant? _____

If so, how far along are you? _____

Height: _____ **Weight:** Currently: _____ Past Maximum: _____ When? _____

Blood Pressure: What is your most recent blood pressure reading? _____/_____ When was this reading taken? _____

If applicable, please list any foods, drugs, or medications you are hypersensitive or allergic to (please include reaction):

_____

_____

_____

Please list any medications (prescribed and over-the-counter), vitamins, and supplements you are currently taking:

_____

_____

_____

Hospitalizations and Surgeries:

Reason	When

X-Rays/CAT Scans/MRI's/NMR's/Special Studies:

Exam	Reason	When

Childhood Illness (please circle any that you have had):

Scarlet Fever Diphtheria Rheumatic Fever Mumps Measles German Measles Chicken Pox

Emotional (please circle any that you experience now and underline any that you have experienced in the past):

Mood Swings Nervousness Mental Tension Anxiety Other:

Have you been diagnosed by a mental health professional with any mental health condition? Y N

If so, what was the diagnosis, and when did you receive it?

Do you currently see a mental health professional? Y N

If yes, what do you see them for?

Do you currently experience any struggles with anxiety, depression, OCD, or any other mental health complaints, diagnosed or undiagnosed? Y N

If so, please briefly describe:

Have you experienced any major traumas in the past? Y N

If yes, please use this space below to describe briefly:

Energy and Immunity (please circle any that you experience now and underline any that you have experienced in the past):

Fatigue Slow Wound Healing Chronic Infections Chronic Fatigue Syndrome

Head, Eye, Ear, Nose, and Throat (please circle any that you experience now and underline any that you have experienced in the past):

Impaired Vision	Eye Pain/Strain	Glaucoma	Glasses/Contacts	Tearing/Dryness
Impaired Hearing	Ear Ringing	Earaches	Headaches	Sinus Problems
Nose Bleeds	Frequent Sore Throats	Teeth Grinding	TMJ/Jaw Problems	Hay Fever
Blurry/Spotty Vision	Sore Throat at night			

Respiratory (please circle any that you experience now and underline any that you have experienced in the past):

Pneumonia	Frequent Common Colds	Difficulty Breathing	Emphysema
Persistent Cough	Pleurisy	Asthma	Tuberculosis
Shortness of Breath	Other Respiratory Problems: _____		

Cardiovascular (please circle any that you experience now and underline any that you have experienced in the past):

Heart Disease	Chest Pain	Swelling of Ankles	High Blood Pressure	
Palpitations/Fluttering	Stroke	Heart Murmurs	Rheumatic Fever	Varicose Veins

Gastrointestinal (please circle any that you experience now and underline any that you have experienced in the past):

Ulcers Changes in Appetite Nausea/Vomiting Epigastric Pain Passing Gas Heartburn

Belching Gall Bladder Disease Liver Disease Hepatitis B or C Hemorrhoids Abdominal Pain

Genito-Urinary Tract (please circle any that you experience now and underline any that you have experienced in the past):

Kidney Disease Painful Urination Frequent UTI Frequent Urination Heavy Flow

Kidney Stones Impaired Urination Blood in Urine Frequent Urination at Night

Female Reproductive/Breasts (please circle any that you experience now and underline any that you have experienced in the past):

Irregular Cycles Breast Lumps/Tenderness Nipple Discharge Heavy Flow

Vaginal Discharge Premenstrual Problems Clotting Bleeding Between Cycles

Menopausal Symptoms Difficulty Conceiving Painful Periods

Menstrual/Birthing History:

1. Age of First Menses: _____ 4. Birth Control Type: _____ 7. # of Abortions: _____

2. # of Days of Menses: _____ 5. # of Pregnancies: _____ 8. # of Live Births: _____

3. Length of Cycle: _____ 6. # of Miscarriages: _____

Male Reproductive (please circle any that you experience now and underline any that you have experienced in the past):

Sexual Difficulties Prostrate Problems Testicular Pain/Swelling Penile Discharge

Musculoskeletal (please circle any that you experience now and underline any that you have experienced in the past):

Neck/Shoulder Pain Muscle Spasms/Cramps Arm Pain Upper Back Pain Mid Back Pain

Low Back Pain Leg Pain Joint Pain (if so, where?): _____

Neurologic (please circle any that you experience now and underline any that you have experienced in the past):

Vertigo/Dizziness Paralysis Numbness/Tingling Loss of Balance Seizures/Epilepsy

Endocrine (please circle any that you experience now and underline any that you have experienced in the past):

Hypothyroid Hypoglycemia Hyperthyroid Diabetes Mellitus Night Sweats Feeling Hot or Cold

Other (please circle any that you experience now and underline any that you have experienced in the past):

Anemia Cancer Rashes Eczema/Hives Cold Hands/Feet

Is there anything else we should know?

LIFESTYLE

Do you currently follow a special diet, or have any food restrictions?

Do you typically eat at least three meals per day? Y N If no, how many? _____

What does your typical eating routine look like?

Do you have any cravings for certainfoods? Y N If so, what do you crave, and when?

Exercise routine:

Spiritual practice:

Sleep

How many hours per night do you sleep? _____ Do you wake rested? Y N

Do you wake in the middle of the night? If so, for what reasons? How often?

Level of education completed: High School Bachelors Masters Doctorate Other

Occupation: _____ Employer: _____ Hours/Week: _____

Do you enjoy work? Y/N Why/Why not? _____

Nicotine/Alcohol/Caffeine use

Are you currently a smoker? Y N How many cigerettes per/day or packs/week do you smoke?

Have you ever consumed nicotine in other ways? (chewing, vapor, etc.) Y N Type: Frequency:

Were you ever a smoker in the past? Y N Quit date:

Cigerettes per day or packs/week: How long have you/did you smoke for?

Alcohol Use

Do you drink alcoholic beverages? How many drinks/week?

Any family history of alcoholism? Y N If yes, who?

Do you have any concerns about your alcohol use?

Caffeine Use

Do you drink caffinated beverages? Y N If so, what do you drink?

How often?

Do you add sugar or another sweetner?

How many glasses of non-caffeinated, non-carbonated beverages do you drink per day?

Television habits: _____ Reading habits: _____

Interests and hobbies: _____

FAMILY HEALTH HISTORY

Family History:	Father	Mother	Brothers	Sisters	Spouse	Children
Check those applicable:						
Age (if living)	_____	_____	_____	_____	_____	_____
Health (G=Good, P=Poor)	_____	_____	_____	_____	_____	_____
Cancer	_____	_____	_____	_____	_____	_____
Diabetes	_____	_____	_____	_____	_____	_____
Heart Disease	_____	_____	_____	_____	_____	_____
High Blood Pressure	_____	_____	_____	_____	_____	_____
Stroke	_____	_____	_____	_____	_____	_____
Mental Illness	_____	_____	_____	_____	_____	_____
Asthma/Hay fever/Hives	_____	_____	_____	_____	_____	_____
Kidney Disease	_____	_____	_____	_____	_____	_____
Age (at death)	_____	_____	_____	_____	_____	_____
Cause of Death	_____	_____	_____	_____	_____	_____

THANK YOU FOR TAKING THE TIME TO COMPLETE THIS THOUROUGH HISTORY,

IT IS EXTREMELY HELPFUL FOR US IN TAILORING YOUR TREATMENT!