zoe lotus healing arts
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Confidential Patient Acupuncture Health History

Name: _____ Date: _____

Date of Birth: _____ Age: _____ Gender: M / F

Marital Status (please circle): Single Married Life Partner Divorced Widowed

Address: _____ City: _____ State: _____ Zip: _____

Occupation: _____ Email: _____

How did you hear about us? _____

Emergency contact:

Name: _____ Phone: _____ Relationship to you: _____

Have you had acupuncture before? Y / N Massage? Y / N For what condition? _____

Reason for your visit today: _____

How and when did this condition begin? _____

What types of treatments have you tried? _____

Please list main health concerns you would like to be free of, in order of importance:

1 _____

2 _____

3 _____

Please list all medications, supplements, herbs and/or vitamins you are taking, current dose, and for what condition:

_____

_____

Please list any known allergies and reactions (seasonal, environmental, food, medication, or otherwise):

_____

Any surgeries, major illnesses, hospitalizations, and major falls/accidents/traumas – include dates:

_____

_____

HEALTH HISTORY (please check only the conditions that apply to you):

- ☐ AIDS/HIV
- ☐ Alcoholism
- ☐ Allergies
- ☐ Anemia
- ☐ Arthritis
- ☐ Asthma
- ☐ Auto-immune dis.
- ☐ Bleeding disorder
- ☐ Breast Cysts
- ☐ Bronchitis
- ☐ Bipolar
- ☐ Cancer
- ☐ Candida(yeast)
- ☐ Chemical dependency
- ☐ Colitis
- ☐ Chicken Pox
- ☐ Diabetes
- ☐ Eating disorder
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Fracture
- ☐ Glaucoma
- ☐ Gallstones
- ☐ Gout
- ☐ Headaches
- ☐ Heart disease
- ☐ Heart murmur
- ☐ Hepatitis
- ☐ Hernia
- ☐ Herniated disc
- ☐ Herpes
- ☐ High Cholesterol
- ☐ High Blood Pressure
- ☐ Kidney Disease
- ☐ Liver disease
- ☐ Low blood pressure
- ☐ Migraine
- ☐ Mononucleosis
- ☐ Multiple Sclerosis
- ☐ Mental Illness
- ☐ Osteoporosis
- ☐ Pacemaker
- ☐ Parkinson's
- ☐ Pneumonia
- ☐ Prostate problems
- ☐ Stroke
- ☐ Substance Addiction/abuse
- ☐ Suicide attempt
- ☐ Thyroid issues
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Venereal dis.
- ☐ Other (please specify) _____

FEMALE REPRODUCTIVE (please check all that apply):

NOW	PAST		NOW	PAST	
☐	☐	Lumps in breast	☐	☐	Painful sex
☐	☐	Nipple discharge	☐	☐	Lack of sexual desire
☐	☐	Breast pain	☐	☐	Menstruation excessive
☐	☐	Pelvic pain	☐	☐	Menstruation absent
☐	☐	Discharge from vagina	☐	☐	Bleed or spot between periods
☐	☐	Vaginal itching/burning	☐	☐	Genital eruptions

Have you ever used birth control pills? Y / N Type and for how long?_____

Have you ever used an I.U.D.? Y / N For how long? _____

Hormone Replacement therapy? Y / N

Are you currently sexually active? Y / N if not, have you been sexually active in the past? Y / N

Current form(s) of contraception _____

Please check any that apply:

☐ menopausal ☐ post-menopause ☐ endometriosis ☐ polycystic ovary disease ☐ pelvic inflammatory disease

Age when menstrual periods began _____

Period every _____ days. Are they regular? Y/N

Periods usually last _____ days (average) Date of last period _____

Please circle : Menses is usually: light / moderate / heavy

I use: tampons / pads / combination Level of absorbency? _____

Please put a B if before period, D if during period, or a A if after period:

_____ abdominal cramping	_____ crying/weepy
_____ backache	_____ anger
_____ water retention/bloating	_____ irritable
_____ breast tenderness	_____ anxiety
_____ headache/migraine	_____ mood changes
_____ depression	_____ hypersensitivity
_____ lethargy	_____ prefer to be left alone
_____ sadness	_____ inability to concentrate
____ clotting	_____ loose stool/diarrhea
_____ food cravings	_____ other symptoms not listed, please describe:_____

Date of last PAP smear _____ Was it normal? Y / N

If not, please explain: _____

Have you ever been diagnosed with HPV? Y / N

Do you currently, or have had in the past, problems with infertility? Y / N

If yes, explain _____

_____

Have you experienced _____ miscarriage? _____ abortion?

Number of children: _____ their age(s):_____

Number of: pregnancies_____ births _____ miscarriages _____ abortions

Any complications of pregnancy? _____ If yes, explain _____

_____

_____

MALE REPRODUCTIVE (please check all that apply):

NOW	PAST		NOW	PAST	
☐	☐	Prostate problems	☐	☐	Painful erection
☐	☐	Swelling, lumps and pain in testicles	☐	☐	Difficult achieving and maintaining erection
☐	☐	Discharge from penis	☐	☐	Difficult ejaculation
☐	☐	Infertility			

Are you currently sexually active? Y / N If not, you been sexually active in the past? Y / N

Type(s) of contraception used? _____

CHINESE BODY SYSTEMS REVIEW

Traditional Chinese Medicine takes into account the well being of the entire person, not just the presenting symptoms.

Please check all that apply to you within the past 3 months:

I tend to feel: ☐ hot ☐ cold ☐ thirsty ☐ I prefer cold drinks ☐ I prefer hot drinks

I experience:
☐ chronic fatigue ☐ weakness ☐ heaviness of head / limbs ☐ dizziness
☐ mental fog ☐ difficulty concentrating ☐ poor memory ☐ insomnia
☐ disturbing dreams ☐ palpitations ☐ ringing in the ears ☐ hot flashes
☐ night sweats ☐ low libido ☐ dry/sore throat ☐ frequent throat clearing
☐ bitter taste in mouth ☐ excessive need for sleep ☐ difficulty losing, gaining, or regulating weight

I have a tendency toward the following emotions:
☐ worry ☐ over thinking ☐ anger
☐ frustration ☐ irritability ☐ feeling stuck ☐ fear ☐ anxiety
☐ panic ☐ sadness ☐ hopelessness

DIGESTION:
☐ low appetite ☐ excessive hunger ☐ gas / bloating after meals
☐ heartburn / acid reflux ☐ belching ☐ nausea ☐ nervous stomach
☐ mouth sores / ulcers ☐ constipation ☐ dry hard stools ☐ loose stools
☐ fluctuates between constipation and loose stools or diarrhea ☐ early morning diarrhea ☐ hemorrhoids

URINARY:
☐ frequent urination ☐ scanty urination ☐ incontinence ☐ history of UTIs
☐ urinating more than once per night

RESPIRATORY:
☐ susceptible to colds / flus / allergies ☐ sinus congestion ☐ chronic cough
☐ dry nose / mouth / throat heaviness of chest ☐ shortness of breath
☐ difficulty in taking nice full deep breaths ☐ frequent sighing

SKIN:
☐ dry skin ☐ eczema ☐ psoriasis ☐ fungal / yeast infections
☐ hair loss ☐ cold hands / feet ☐ spontaneous sweating ☐ heat sensation palms / soles

MUSCULAR / SKELETAL:
☐ neck / shoulder tension ☐ low back pain ☐ sore / weak knees
☐ tenderness in muscles ☐ muscle spasms ☐ numbness / tingling ☐ jaw pain
☐ joint pain ☐ popping / cracking of joints ☐ sciatica ☐ feel better after exercise
☐ feel worse after exercise

LIFESTYLE: Do you follow a specific diet? Y / N If so, please explain: _____
How often do you exercise? _____ What type(s) of exercise _____
Do you make time for relaxation / meditation / prayer? Y / N
How many hours of sleep do you typically get? _____ Do you wake rested? Y / N
Do you have trouble falling or staying asleep? Y / N
Please check all that apply : ____coffee / caffeine ____sugar ____alcohol ____smoking ____recreational drugs

Thank you for taking the time to fill out this health history. Please read below and sign:
The above information is true, accurate and complete to the best of my knowledge. I will make my practitioner aware of any changes to any and all of the information above.

Signature _____ Date: _____