Little Birds
ACUPUNCTURE

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New Patient Health History

ALL INFORMATION WILL REMAIN CONFIDENTIAL

Name_____ Date_____

❑ Male ❑ Female DOB ____/____/_____ Age_____

Address_____

City/State/Zip_____

Phone: (Cell) _____ (Home) _____ (Work) _____

We value your privacy and from time to time we send out email, text and mail communication updates, would you like to receive?

Email ❑ Yes ❑ No Email Address_____
Text ❑ Yes ❑ No
Mail ❑ Yes ❑ No

Marital Status ❑ Single ❑ Married ❑ Divorced ❑ Widowed

Emergency Contact: _____ Phone: _____

Whom may we thank for your referral? _____

☯ Primary reason for today's visit? _____

_____

What was the initial cause? _____

How long have you had this problem? _____

What diagnosis have you received for this condition?_____

What kinds of treatments have you tried? _____

Does anything improve your problem? _____

Does anything make your condition worse? _____

Have you had acupuncture treatment in the past? ❑ Yes ❑ No Date of last treatment_____

Are you currently under a physician's care? ❑ Yes ❑ No

Name of Physician: _____ Phone: _____

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. Thank you.

Family Medical History

(if known)

Mother's Health Challenges_____ Living/Deceased

Father's Health Challenges_____ Living/Deceased

Sibling's Health Challenges_____

Medical History

Were you born prematurely or were there any unusual circumstances with your birth? Please explain.

_____

Childhood Illnesses? _____

How was your overall childhood health?_____

Have you had any serious illnesses as an adult? Please list with approximate age.

_____

Any significant traumas (auto accidents, falls, injuries)? Please list with approximate age.

_____

Allergies? (drugs, chemical, animals, seasonal or environmental) _____

_____

Are you allergic to metal? ❑ Yes ❑ No

Do you have a pacemaker? ❑ Yes ❑ No

Are you pregnant? ❑ Yes ❑ No

Do you have any significant scarring or keloid scarring? ❑ Yes ❑ No Where? _____

What was your most recent Blood Pressure reading (if known)? _____/_____

Medications:

_____ For what condition? _____

_____ For what condition? _____

_____ For what condition? _____

_____ For what condition? _____

_____ For what condition? _____

Have you frequently used antibiotics (>3 times a year)? ❑ Yes ❑ No
Have you used antibiotics long-term? ❑ Yes ❑ No
Have you used steroids long-term? ❑ Yes ❑ No

Please list any over-the-counter drugs, vitamins, supplements, herbs, or homeopathic medications that you have taken within the last three months.

_____

_____

Personal History / Lifestyle

Current Quality of Life: _____

Current Emotional Health: _____

Stress Level (1-10): _____

Occupation: _____

Have you had any unusual stresses lately? Please explain. _____

_____

Hobbies & Recreation: _____

Have you traveled abroad in the last year? ❑ Yes ❑ No Where?_____

How is your energy level? _____

Time of day energy is Highest: _____ Lowest: _____

Do you exercise regularly? ❑ Yes ❑ No How many days per week? _____

Type of exercise? _____

How much water do you drink daily? _____

Are you vegetarian, vegan, gluten-free, dairy-free or on any special diet? Please explain. _____

_____

Do you smoke cigarettes/cigars? ❑ Yes ❑ No If former tobacco use, # of years quit _____

If yes, how much per day? _____ How many years? _____

Do you drink alcohol? ❑ Yes ❑ No How many days per week?_____

How many hours do you sleep a night? _____ Dreams: ❑ Yes ❑ No

How long does it take you to fall asleep? _____

Do you wake at night? ❑ Yes ❑ No

How many times do you wake up? _____

Are you able to get back to sleep ❑ Yes ❑ No

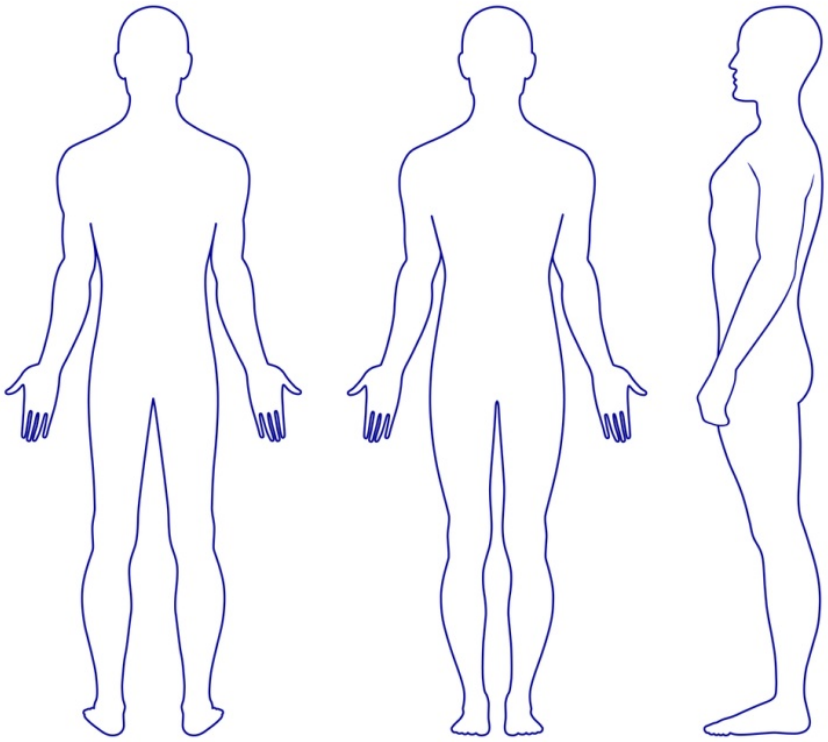
Medical Conditions (past & present)

- ❑ Aids/HIV
- ❑ Alcoholism
- ❑ Alzheimer's
- ❑ Anemia
- ❑ Asthma
- ❑ Autoimmune Disease
- ❑ Bleeding Disorder
- ❑ Cancer
- ❑ Chronic Fatigue/ME
- ❑ Connective Tissue Disease
- ❑ COPD
- ❑ Diabetes (Type 1 or 2)
- ❑ Drug Addiction
- ❑ Emphysema
- ❑ Endocrine Disorder
- ❑ Epilepsy
- ❑ Epstein Barr Virus/Mono
- ❑ Fibromyalgia
- ❑ Gallbladder Disease
- ❑ Gallstones
- ❑ Hepatitis
- ❑ Gout
- ❑ Heart Disease
- ❑ High Blood Pressure
- ❑ Jaundice
- ❑ Joint Replacement
- ❑ Kidney Stones
- ❑ Low Blood Pressure
- ❑ Lupus
- ❑ Mental Disorder
- ❑ Migraines
- ❑ Muscular Dystrophy
- ❑ Muscular Sclerosis
- ❑ Osteoarthritis
- ❑ Osteoporosis
- ❑ Parkinson's Disease
- ❑ Pulmonary Disease
- ❑ Rheumatoid Arthritis
- ❑ Seizures
- ❑ Strokes
- ❑ Thyroid Disease (hyper/hypo)
- ❑ Tuberculosis
- ❑ Vein Condition
- ❑ Venereal Disease

I have or have had an *infectious disease* (i.e. HIV, Hepatitis) ❑ Yes ❑ No

Yes, please explain: _____

Please mark on the figures below any areas where you are experiencing PAIN or DISCOMFORT.



Pain description: ❑ Acute ❑ Chronic ❑ Dull ❑ Sharp/Stabbing ❑ Cramping ❑ Spasms ❑ Burning ❑ Tingling ❑ Numbness ❑ Radiating ❑ Moves About

Pain intensity: ❑ Mild ❑ Moderate ❑ Severe

Sleeping: ❑ No problem ❑ Disturbed ❑ Very disturbed ❑ Can not sleep

Frequency: ❑ 25% of time ❑ 50% of time ❑ 75% of time ❑ Always

Walking: ❑ No problem ❑ Pain after short distance ❑ Unable to walk without pain

Sitting: ❑ No problem ❑ Some pain ❑ Can not sit without pain

Do any of the following lessen your pain? ❑ Heat ❑ Cold ❑ Pressure ❑ Exercise

Do any of the following worsen your pain? ❑ Heat ❑ Cold ❑ Pressure ❑ Exercise

Prior treatments for your pain? ❑ Medication ❑ Blocks/Injections ❑ Surgery ❑ Physical Therapy ❑ Chiropractic ❑ Massage ❑ Other _____

PLEASE CHECK YOUR CURRENT SYMPTOMS (< 3 months)

General Symptoms

- ❑ Always Cold
- ❑ Always Hot
- ❑ Bleeding/Bruising
- ❑ Chills
- ❑ Chronic Mental Cloudiness
- ❑ Fatigue/Sudden Energy Drops
- ❑ Fevers
- ❑ Mood Swings
- ❑ Recent Weight Gain
- ❑ Recent Weight Loss
- ❑ Insomnia/Poor Sleep
- ❑ Dream Disturbed Sleep
- ❑ Trouble Falling Asleep
- ❑ Trouble Staying Asleep
- ❑ Peculiar Tastes/Smells
- ❑ Strongly Prefer Hot Drinks
- ❑ Strongly Prefer Cold Drinks

Respiratory System

- ❑ Asthma
- ❑ Bronchitis
- ❑ Congestion
- ❑ Cough
- ❑ Coughing Blood
- ❑ Difficulty Breathing
- ❑ Easily Winded
- ❑ Frequent Cold/ Flu
- ❑ Pain with Deep Breaths
- ❑ Phlegm
- ❑ Pneumonia
- ❑ Shortness of Breath
- ❑ Tight Chest
- ❑ Wheezing

Digestive System

- ❑ Abdominal Pain/Cramps
- ❑ Acid Reflux
- ❑ Bad Breath
- ❑ Belching
- ❑ Bloating
- ❑ Blood in Stool
- ❑ Colitis
- ❑ Constipation
- ❑ Diarrhea/Loose Stool
- ❑ Excessive Hunger
- ❑ Food Allergies/Sensitivities
- ❑ Gall Bladder Disorder
- ❑ Gall Stones
- ❑ Gas/Flatulence
- ❑ Heartburn
- ❑ Hemorrhoids
- ❑ Hernia
- ❑ Hiccups
- ❑ Indigestion
- ❑ Irritable Bowel Syndrome (IBS)
- ❑ Mucus in Stool
- ❑ Nausea
- ❑ Poor Appetite
- ❑ Recent Change in Appetite
- ❑ Rectal Pain/Itching
- ❑ Stomach Pain
- ❑ Ulcers
- ❑ Use Antacids
- ❑ Use Fiber
- ❑ Use Laxatives
- ❑ Vomiting

Bowel Movements

- ❑ 1 X per day
- ❑ Less than 1 X per day
- ❑ More than 1 X per day

Head, Eyes, Ears, Nose, Throat

- ❑ Blurred Vision
- ❑ Cataracts
- ❑ Cold Sores
- ❑ Concussions
- ❑ Difficulty Swallowing
- ❑ Double Vision
- ❑ Dry Eyes
- ❑ Dry Mouth
- ❑ Dry Nose
- ❑ Ear Infections
- ❑ Earaches
- ❑ Enlarged Thyroid
- ❑ Excessive Saliva
- ❑ Excessive Thirst
- ❑ Eye Floaters/Spots in Vision
- ❑ Eye Inflammation
- ❑ Eye Pain/Strain
- ❑ Eye Redness
- ❑ Facial Numbness
- ❑ Facial Pain
- ❑ Feeling of Lump in Throat
- ❑ Frequent Sore Throat
- ❑ Glaucoma
- ❑ Gum Problems
- ❑ Hay Fever/Allergies
- ❑ Hearing Aid
- ❑ Hearing Loss
- ❑ Itchy Eyes
- ❑ Jaw/Teeth Pain/TMJ
- ❑ Loss of Voice
- ❑ Mouth or Tongue Sores/Ulcers
- ❑ Nasal Congestion
- ❑ Night Blindness
- ❑ Nosebleeds
- ❑ Ringing of Ears/Tinnitus
- ❑ Sinus Issues/Pain
- ❑ Swollen Glands
- ❑ Tearing
- ❑ Teeth Grinding
- ❑ Throat Drainage
- ❑ Vertigo
- ❑ Vision Problems

Musculoskeletal

- ❑ Arthritis
- ❑ Bursitis
- ❑ Carpal Tunnel Syndrome
- ❑ General Aches
- ❑ Golfer's Elbow
- ❑ Joint Pain/Dysfunction
- ❑ Limited Range of Motion
- ❑ Muscle Weakness/Atrophy
- ❑ Plantar Fasciitis
- ❑ Recent Sprain
- ❑ Sciatica
- ❑ Scoliosis
- ❑ Tendonitis
- ❑ Tennis Elbow
- ❑ Weather Related Pain
- ❑ Whiplash

Cardiovascular System

- ❑ Angina
- ❑ Atherosclerosis
- ❑ Arteriosclerosis
- ❑ Blood Clots
- ❑ Chest Pain/Tightness
- ❑ Cold hands/feet
- ❑ Edema
- ❑ Fainting
- ❑ Heart Attack
- ❑ Heart Murmur
- ❑ Irregular Heart Rate/Beat
- ❑ Mitral Valve Prolapse
- ❑ Palpitations
- ❑ Phlebitis
- ❑ Poor Balance
- ❑ Poor Circulation
- ❑ Rapid Heart Rate
- ❑ Stroke
- ❑ Swelling of hands/feet
- ❑ Thrombosis
- ❑ Varicose Veins

Skin & Hair

- ❑ Acne
- ❑ Burns
- ❑ Dandruff
- ❑ Dermatitis
- ❑ Dry Skin
- ❑ Easily Bruise
- ❑ Eczema
- ❑ Excessive Sweating
- ❑ Fungal Infections
- ❑ Hair Loss
- ❑ Hives
- ❑ Itching
- ❑ Night Sweating
- ❑ Oily Skin
- ❑ Premature Graying
- ❑ Psoriasis
- ❑ Rashes
- ❑ Scars
- ❑ Thin, Slow Growing Nails
- ❑ Ulcerations

Urinary System

- ❑ Bedwetting
- ❑ Blood in Urine
- ❑ Burning with Urination
- ❑ Dribbling of Urine
- ❑ Frequent Urination
- ❑ Frequent UTI
- ❑ Incomplete Urination
- ❑ Incontinence
- ❑ Kidney Stones
- ❑ Pain/Itching of Genitalia
- ❑ Pain with Urination
- ❑ Urgent Urination
- ❑ Wake to Urinate

Neurological

- ❑ Areas of Numbness
- ❑ Concussion
- ❑ Difficult Concentration
- ❑ Disorientation
- ❑ Dizziness
- ❑ Headaches or Migraines
- ❑ Lack of Coordination
- ❑ Loss of Balance
- ❑ Numbness/Tingling
- ❑ Paralysis
- ❑ Poor Memory
- ❑ Seizures
- ❑ Sleep Disorders
- ❑ Shingles
- ❑ Spinal Cord Injury
- ❑ Tremors

Neuro-Physiological

- ❑ Abuse Survivor
- ❑ Anxiety
- ❑ Boredom
- ❑ Depression
- ❑ Easily Angered/ Frustrated/ Stressed
- ❑ Emotional Numbness
- ❑ Excess Worry
- ❑ Easily Frightened
- ❑ Irritable
- ❑ Obsessiveness
- ❑ Overly Emotional
- ❑ Panic Attacks
- ❑ Unresolved Grief

- ❑ Receiving Counseling
- ❑ Received Counseling

WOMEN

Are you pregnant? ❑ Yes ❑ No If yes, how many weeks? _____

Age of first period _____ # of days of cycle? _____ # of days of bleeding? _____

Date of last period _____ Describe Flow: ❑ Light ❑ Medium ❑ Heavy

Blood clots during period? ❑ Yes ❑ No Color of Blood? ❑ Pale ❑ Red ❑ Dark Red

Any Vaginal Discharge? ❑ Yes ❑ No Color? _____ Itching/Burning? ❑ Yes ❑ No

Do you experience emotional changes before or during your periods? ❑ Yes ❑ No

Do you use oral contraceptives? ❑ Yes ❑ No

Number of Pregnancies _____ # of Births_____ Miscarriages? ❑ Yes ❑ No

Hysterectomy? ❑ Yes ❑ No Age? _____ Age of Menopause? _____

Are you receiving HRT? ❑ Yes ❑ No

Female Reproductive System

- ❑ Breast Problems
- ❑ Breast Fibroids
- ❑ Endometriosis
- ❑ Fertility Issues
- ❑ Irregular Menstruation
- ❑ Menopausal /Perimenopausal Symptoms
- ❑ Ovarian Cysts
- ❑ Painful Menstruation
- ❑ PCOS
- ❑ PMS
- ❑ Uterine Fibroids

MEN

Male Reproductive System

- ❑ Groin Area Pain
- ❑ Impotence
- ❑ Infertility
- ❑ Penile Discharge
- ❑ Prostate Problems
- ❑ Sexual Difficulties
- ❑ Testicular Pain

Are there any other disorders that we should be aware of?

_____

Are there any additional concerns you wish to discuss?

_____