**New Leaf Acupuncture and Reiki – Health History Form for Acupuncture**

**Patient Information**

Name_____ Date of Birth_____ Age_____ Occupation_____

Address_____ City_____ State_____ Zip_____

Cell Phone_____ Home Phone _____ Work Phone_____

Best phone # (circle one): Home Cell Work It is okay to leave a message on (circle all that apply): Home Cell Work

Email_____ May we add you to our email list? Emails are infrequent. We hate SPAM, too, and would never share your email with anyone! □ Yes □ No

Referred by_____ May we thank them for your referral? □ Yes □ No

Please circle: Single Partnered Married Separated Divorced Widowed Children (Ages):_____

Emergency Contact_____ Relationship_____ Best number to reach them_____

Primary physician_____ Phone_____

Have you had acupuncture before? □ Yes □ No If so, when and for what?_____

**Goals:** What would you like to address through treatment?_____

_____

_____

_____

_____

Other treatment you have tried/are currently receiving?_____

**Medications/Supplements:** Please include prescriptions, over the counter medications, vitamins and supplements.

| **Name** | **Dosage** | **Reason taking** | **Prescribed/suggested by** | **Started when** |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

**Allergies:** Please list all known allergies. _____

_____

**Family History:** Check illnesses that have occurred in blood relatives**.** □ Cancer □ Depression/mental illness □ Diabetes □ Drug/alcohol abuse □ Heart disease □ High blood pressure □ Kidney disease □ Stroke

**Lifestyle**

Check which substances you use and describe how much you use.
☐ Caffeine_____
☐ Drugs_____
☐ Alcohol_____
☐ Tobacco_____
☐ Sugar_____

Check if your work or lifestyle exposes you to these.
☐ Stress
☐ Insufficient sleep
☐ Very long working hours Average hours per week_____
☐ Long commuting times
☐ Heavy lifting or hazardous substances
☐ Other_____

Exercise: Do you exercise regularly? ☐Yes ☐ No If so, please describe activities and frequency:_____

_____

How do you feel after you exercise (e.g.: energized, drained)?_____

Sleep: When do you go to bed?_____ How long does it take you to fall asleep?_____ When do you get up?_____ How many hours of sleep do you average?_____ How many hours do you need to feel rested?_____ If your sleep is disrupted or disturbed, describe_____
Do you get up at night to urinate? ☐ Yes ☐ No How often?_____

Diet: Are you vegetarian? ☐Yes ☐ No If so, how long and what type?_____

Typical breakfast:_____

Typical lunch:_____

Typical dinner:_____

Snacks:_____ When do you typically snack?_____

What do you crave?_____

How much water do you drink per day on average? # Servings_____ Serving size_____

Do you prefer your beverages to be (circle best fit): Iced Cold Room temperature Warm

**Pain:** For any areas of pain or discomfort you have now, please complete the following:

| **Location** | **Sensation** (Circle) | **Better from** (Circle) | **Worse from** (Circle) |
|---|---|---|---|
| _____ | Sharp Stabbing Dull Ache Numb Burning Tingling Other | Heat Cold Pressure Rest Movement Other | Heat Cold Pressure Rest Movement Other |
| _____ | Sharp Stabbing Dull Ache Numb Burning Tingling Other | Heat Cold Pressure Rest Movement Other | Heat Cold Pressure Rest Movement Other |
| _____ | Sharp Stabbing Dull Ache Numb Burning Tingling Other | Heat Cold Pressure Rest Movement Other | Heat Cold Pressure Rest Movement Other |

**Surgeries/Accidents:** Include car accidents and any likely concussions.
_____ Date_____
_____ Date_____
_____ Date_____

How long has it been since your last complete medical exam?_____

**Symptoms: Check all that apply. NOW = WITHIN LAST 3 MONTHS PAST = ANY TIME BEFORE THAT**

**General**

| Now | Past | Symptom | Now | Past | Symptom | Now | Past | Symptom |
|---|---|---|---|---|---|---|---|---|
| ☐ | ☐ | Bleed/bruise easily | ☐ | ☐ | Insomnia | ☐ | ☐ | Sudden energy drop |
| ☐ | ☐ | Catch colds easily | ☐ | ☐ | Localized weakness | ☐ | ☐ | Sweating easily |
| ☐ | ☐ | Change in appetite | ☐ | ☐ | Night sweats | ☐ | ☐ | Tremors |
| ☐ | ☐ | Chills | ☐ | ☐ | Poor appetite | ☐ | ☐ | Weight gain |
| ☐ | ☐ | Disturbed sleep | ☐ | ☐ | Poor balance | ☐ | ☐ | Weight loss |
| ☐ | ☐ | Fever | ☐ | ☐ | Strong thirst | | | |

**Cardiovascular**

| Now | Past | Symptom | Now | Past | Symptom | Now | Past | Symptom |
|---|---|---|---|---|---|---|---|---|
| ☐ | ☐ | Blood clots | ☐ | ☐ | High blood pressure | ☐ | ☐ | Previous heart attack |
| ☐ | ☐ | Chest pain | ☐ | ☐ | Irregular heartbeat | ☐ | ☐ | Swelling of ankles/hands |
| ☐ | ☐ | Cold hands/feet | ☐ | ☐ | Lightheaded | | | |
| ☐ | ☐ | Fainting | ☐ | ☐ | Low blood pressure | | | |
| ☐ | ☐ | Hardening of arteries | ☐ | ☐ | Palpitations | | | |

**Digestive**

| Now | Past | Symptom | Now | Past | Symptom | Now | Past | Symptom |
|---|---|---|---|---|---|---|---|---|
| ☐ | ☐ | Abdominal pain/cramps | ☐ | ☐ | Chronic laxative use | ☐ | ☐ | Indigestion |
| ☐ | ☐ | Bad breath | ☐ | ☐ | Constipation | ☐ | ☐ | Nausea |
| ☐ | ☐ | Belching | ☐ | ☐ | Diarrhea | ☐ | ☐ | Rectal pain |
| ☐ | ☐ | Black stools | ☐ | ☐ | Excessive hunger | ☐ | ☐ | Reflux |
| ☐ | ☐ | Bloating | ☐ | ☐ | Gall bladder trouble | ☐ | ☐ | Vomiting |
| ☐ | ☐ | Blood in stools | ☐ | ☐ | Gas | Other digestive symptoms_____ | | |
| | | | ☐ | ☐ | Hemorrhoids | | | |

**Genito/Urinary**

| Now | Past | Symptom | Now | Past | Symptom | Now | Past | Symptom |
|---|---|---|---|---|---|---|---|---|
| ☐ | ☐ | Blood/pus in urine | ☐ | ☐ | Frequent night urination | ☐ | ☐ | Pain/burning on urination |
| ☐ | ☐ | Decreased libido | ☐ | ☐ | Inability to hold urine | ☐ | ☐ | STDs_____ |
| ☐ | ☐ | Decreased urine flow | ☐ | ☐ | Kidney infection/stones | ☐ | ☐ | Urgent urination |
| ☐ | ☐ | Frequent urination | | | | | | |

**Head, Eyes, Ears, Nose, Throat**

| Now | Past | Symptom | Now | Past | Symptom | Now | Past | Symptom |
|---|---|---|---|---|---|---|---|---|
| ☐ | ☐ | Cataracts | ☐ | ☐ | Headaches | ☐ | ☐ | Ringing in ears |
| ☐ | ☐ | Concussions | ☐ | ☐ | Hoarseness | ☐ | ☐ | Sinus problems |
| ☐ | ☐ | Dizziness | ☐ | ☐ | Jaw clicking/pain/TMJ | ☐ | ☐ | Spots/floaters in front of eyes |
| ☐ | ☐ | Earaches | ☐ | ☐ | Lip or tongue sores | | | |
| ☐ | ☐ | Enlarged glands | ☐ | ☐ | Migraines | ☐ | ☐ | Taste/smell problems |
| ☐ | ☐ | Eye pain/strain | ☐ | ☐ | Nose bleeds | ☐ | ☐ | Teeth problems |
| ☐ | ☐ | Facial pain | ☐ | ☐ | Poor hearing | ☐ | ☐ | Vision problems (blurry, poor, night) |
| ☐ | ☐ | Grinding teeth | ☐ | ☐ | Recurrent sore throats | | | |

**Musculoskeletal**

| Now | Past | Symptom |
|---|---|---|

Pain in: ☐ Arms ☐ Hands ☐ Wrists ☐ Shoulders ☐ Neck ☐ Back ☐ Hips ☐L egs ☐ Ankles ☐ Feet

| Now | Past | Symptom |
|---|---|---|
| ☐ | ☐ | Arthritis |
| ☐ | ☐ | Limited range of motion |
| ☐ | ☐ | Muscle cramps |
| ☐ | ☐ | Muscle pain |
| ☐ | ☐ | Muscle weakness |
| ☐ | ☐ | Pain worse in hot/humid weather |
| ☐ | ☐ | Pain worse during cold weather |
| ☐ | ☐ | Restless leg |
| ☐ | ☐ | Swollen/weak/painful joints |

Other joint/muscle symptoms_____

**Neuro-Psychological**

| Now | Past | Symptom |
|---|---|---|
| ☐ | ☐ | Anxiety |
| ☐ | ☐ | Compulsive behavior |
| ☐ | ☐ | Depression |
| ☐ | ☐ | Difficulty in focusing |
| ☐ | ☐ | Easily startled |
| ☐ | ☐ | Excessive anger |
| ☐ | ☐ | Excessive fear |
| ☐ | ☐ | Excessive worry |
| ☐ | ☐ | Irritability |
| ☐ | ☐ | Loss of balance |
| ☐ | ☐ | Numbness/tingling of limbs |
| ☐ | ☐ | Overwhelmed by life |
| ☐ | ☐ | Poor memory |
| ☐ | ☐ | Seizures |
| ☐ | ☐ | Suicidal thoughts |
| ☐ | ☐ | Trauma |
| ☐ | ☐ | Tremors |

Please list therapy, medication and/or other treatment for emotional support:_____

**Respiratory**

| Now | Past | Symptom |
|---|---|---|
| ☐ | ☐ | Asthma/wheezing |
| ☐ | ☐ | Bronchitis |
| ☐ | ☐ | Coughing up blood |
| ☐ | ☐ | Difficulty breathing |
| ☐ | ☐ | Easily winded |
| ☐ | ☐ | Excessive phlegm – color? _____ |
| ☐ | ☐ | Painful breathing |
| ☐ | ☐ | Persistent cough |
| ☐ | ☐ | Pneumonia |

Other respiratory symptoms_____

**Skin & Hair**

| Now | Past | Symptom |
|---|---|---|
| ☐ | ☐ | Boils |
| ☐ | ☐ | Dandruff |
| ☐ | ☐ | Dry skin |
| ☐ | ☐ | Eczema |
| ☐ | ☐ | Hair thinning |
| ☐ | ☐ | Hives |
| ☐ | ☐ | Itching |
| ☐ | ☐ | Lumps |
| ☐ | ☐ | Rashes |
| ☐ | ☐ | Sore that won't heal |

Other skin/hair Symptoms_____

**For Men:** Do you have any bothersome urinary or genital symptoms: ☐ Yes ☐ No
Any sexual dysfunction (erectile, etc.)? ☐ Yes ☐ No

**For Women:** Age: First period_____ Menopause (if applicable)_____ Date: Last pap smear____ Last mammogram_____
Date of last period:_____ Average number of days of flow_____ The flow is: ☐ Normal ☐ Heavy ☐ Light
The color is: ☐ Bright red ☐ Dark red ☐Purple ☐ Light brown ☐ Dark brown Average # of days between periods_____
Are you pregnant now? ☐ Yes ☐ No ☐Unsure Number of: Live births_____ Miscarriages _____ Abortions_____
Have you ever been on the pill? ☐ Yes ☐ No If applicable, are you currently using birth control? ☐ Yes ☐ No If yes, what type and for how long?_____
If interested in fertility support, please describe any concerns and methods used to date:_____
_____

| Now | Past | Symptom |
|---|---|---|
| ☐ | ☐ | Abnormal pap smear |
| ☐ | ☐ | Bleeding/spotting between periods |
| ☐ | ☐ | Breast lumps |
| ☐ | ☐ | Breast tenderness |
| ☐ | ☐ | Fertility issues |
| ☐ | ☐ | Fibroids |
| ☐ | ☐ | Hot flashes |
| ☐ | ☐ | Irregular cycle |
| ☐ | ☐ | Menstrual clots |
| ☐ | ☐ | Ovarian cysts |
| ☐ | ☐ | Painful period |
| ☐ | ☐ | PMS |
| ☐ | ☐ | UTIs |
| ☐ | ☐ | Vaginal discharge |
| ☐ | ☐ | Vaginal dryness |
| ☐ | ☐ | Yeast infections |

Other_____