The People's Acupuncture of Asheville
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PATIENT INFORMATION	CONTACT INFORMATION
Date_____ Name_____ Address_____ City State Zip_____ Age_____ Birth Date_____ Occupation_____ How did you hear about us? _____	Phone Number _____ Email _____ Another person we may contact if needed: Name _____ Relationship_____ Phone Number _____

HEALTH HISTORY

What are your primary concerns for coming in for treatment?

1. _____
2. _____
3. _____

How is your sleep? _____

_____

How is your digestion?

_____

_____

List medications or food supplements you are taking.

_____

_____

_____

List serious illnesses, accidents, or surgeries.

_____

_____

_____

Past and current treatments used for primary concerns.

_____

_____

Check symptoms you have or have had in the last year:

___ Depression	___ Difficulty in focusing.
___ Headache	___ Excessive fear
___ Dizziness	___ Excessive worry
___ Easily startled	___ Fatigue/tiredness.
___ Nervousness	___ Excessive anger
___ Irritability	___ Loss of/poor sleep
___ Overwhelmed by life	___ Loss/gain of weight

Check conditions you have or have had in the past:

___ Allergies	___ Cancer
___ Anemia	___ Diabetes
___ Bleeding disorders	___ Arthritis
___ Breast lump	___ AIDS

How long has it been since you've had a complete medical exam? _____

Check illnesses that have occurred in blood relatives.

___ Diabetes	___ High blood pressure
___ Stroke	___ Kidney disease
___ Cancer	___ Heart disease

TURN OVER

HEALTH HISTORY (CONT.)

Check symptoms you have or had in the last year:

MUSCLE/JOINT/BONES

___ Tremors ____Cramps ___ Swollen Joints

Pain, weakness, numbness in:

___ Arms or hips ___ Neck
___ Back of legs ___ Hands
___ Feet ___ Shoulders

Other_____

THROAT/RESPIRATORY

___ Asthma/wheezing ___ Gum trouble
___ Difficulty breathing ___ Eye pain
___ Sinus problems ___ Blurred or failing vision
___ Frequent sinus infections ___ Enlarged glands
___ Persistent cough ___ Ringing in ears
___ Allergies ___ Loss of hearing
___ Hoarseness ___ Earache
___ Frequent colds ___ Nose bleeds

SKIN

___ Boils ___ Sensitive skin
___ Bruise easily ___ Sore won't heal.
___ Dry skin ___ Itching/rash
___Eczema, psoriasis, dermatitis ___ Acne/cysts

CARDIOVASCULAR

___ Previous heart attack ___ High or low blood pressure
___ Hardening of arteries ___ Rapid/Irregular heartbeat
___ Poor circulation ___ Pain over heart
___ Ankle swelling.
___ Chest pain

IMPLANTED MEDICAL DEVICES

___ Metal screws, pins, plates, or rods
Where? _____
___ Pacemaker/defibrillator ___ Stents
Other _____

GASTROINTESTINAL

___ Pain over stomach ___Cramping
___ Gall bladder trouble ___ Nausea
___ Hemorrhoids ___ Diarrhea
___ Difficulty swallowing ___ Poor appetite
___ Belching, gas, bloating ___ Colon trouble
___ Acid Reflux ___ Indigestion
___ Constipation ___ Excessive hunger
___ Gurgling

GENITO/URINARY

___ Blood/pus in urine ___ Frequent urination
___ Kidney infection/stones ___ Lowered libido
___ Incontinence

___ Erection difficulties ___ Penis discharge
___ Prostate trouble

___ IUD ___ Currently use. birth control pill
___ Previous miscarriage ___ Perimenopausal symptoms
___ Traumatic childbirth ___ Menopausal
___ C Section ___ Hysterectomy
___ Excessive blood loss from childbirth ___ Irregular period
___ Regular period ___ Scanty
___ Extremely painful ___ Excessively heavy period
___ Too frequent ___ Pain with ovulation
___ Bleeding in between
___ Cysts or fibroids
___ Extreme PMS

How many childbirths have you had? _____

Could you be pregnant? _____

The information on this form is correct to the best of my knowledge.

Signature_____ Date_____