

**Yinessence Acupuncture Health History Form**

Date: \_\_\_\_\_

Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Email: \_\_\_\_\_ Phone#: \_\_\_\_\_

Occupation: \_\_\_\_\_

Have You Had Acupuncture Previously?      Yes      No

How Did You Hear About Us?: \_\_\_\_\_

Allergies- Food: \_\_\_\_\_

Allergies- Contact: \_\_\_\_\_

Allergies- Medication: \_\_\_\_\_

Medical History (significant illness, surgeries, etc):

Pertinent family medical history:

## Main Complaint

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When did this start? \_\_\_\_\_

Heat makes it:            better            no change            worse

Cold makes it:            better            no change            worse

Damp weather:            better            no change            worse

Exercise/Activity:            better            no change            worse

Please rate the intensity of this complaint 0 being none to 10 being the worst you can imagine.

Mark **B** for when intensity is at its **BEST** and **W** for when intensity is at its **WORST**.

0 <-----1-----3-----5-----7-----9----->10

Have you seen other specialists for this issue?

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## Secondary Complaint

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When did this start? \_\_\_\_\_

Heat makes it:            better            no change            worse

Cold makes it:            better            no change            worse

Damp weather:            better            no change            worse

Exercise/Activity:            better            no change            worse

Please rate the intensity of this complaint 0 being none to 10 being the worst you can imagine.

Mark **B** for when intensity is at its **BEST** and **W** for when intensity is at its **WORST**.

0 <-----1-----3-----5-----7-----9----->10

Have you seen other specialists for this issue?

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**Please describe your habits regarding the following:**

Diet:

Water/fluid intake:

Exercise:

Tobacco:

Recreational drugs:

Alcohol:

Sleep:

Bowels:

Urination:

**Please describe any issues/relevant details about the following:**

Energy:

Immune system:

Skin:

Hair/Nails:

Eyes:

Dizziness/vertigo:

Respiration:

**Women, please fill out all that apply:**

Are your cycles regular (28-32 days)? \_\_\_\_\_

Last period date: \_\_\_\_\_

How long does your period typically last? \_\_\_\_\_

Do you ovulate? \_\_\_\_\_

Are you taking any type of BCP or other hormonal therapy? \_\_\_\_\_

Are there any PMS or period symptoms you would like to discuss?

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# Pregnancies: \_\_\_\_\_ # Births \_\_\_\_\_ Are you pregnant? \_\_\_\_\_

Are you trying to conceive? \_\_\_\_\_ If so, how long? \_\_\_\_\_

Are you exploring other methods of conception - IVF, IUI, medications, herbal supplements?

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History of OB/GYN issues (PCOS, endometriosis, etc ), surgeries?

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Are you experiencing any menopause type symptoms?

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