

**Eagle River Acupuncture
Patient Information and Health History**

Name _____

Address _____

Home Phone _____ Work Phone _____

Cell Phone _____ Email _____

Today's Date _____ Birth Date _____

Marital Status _____ Name of Partner _____

Children? _____ Names _____

Length of current relationship _____ Place of Birth _____

Education _____ Occupation _____

What brings you to acupuncture? _____

Date of Last Physical Exam _____ By Whom? _____

How did you hear about us? _____

Please List All Medications You Are Taking:

_____ Amount _____ Prescribed? _____

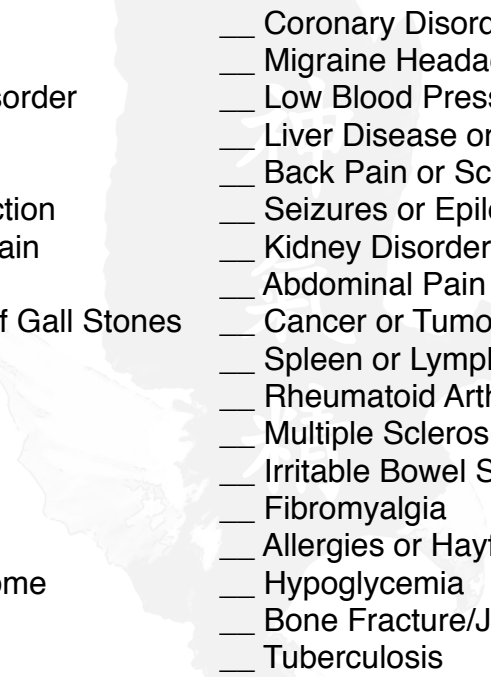
_____ Amount _____ Prescribed? _____

_____ Amount _____ Prescribed? _____

_____ Amount _____ Prescribed? _____

_____ Amount _____ Prescribed? _____

Health History: Have you ever been diagnosed with any of the following?

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- Tension Headaches
 - High Blood Pressure
 - Lung or Respiratory Disorder
 - TMJ Disorder
 - Stroke
 - Urinary or Bladder Infection
 - Chest Pain or Angina Pain
 - Concussion
 - Gall Bladder Disorder or Gall Stones
 - Pelvic or Genital Pain
 - HIV+ or AIDS
 - Gastric or Peptic Ulcer
 - Osteoarthritis
 - Polio or Mononucleosis
 - Diabetes Mellitus
 - Chronic Fatigue Syndrome
 - Asthma or Bronchitis
 - Thyroid Disorder
 - Muscle Spasm or Tremor
 - Pneumonia
 - Pre-Menstrual Syndrome
 - Tennis Elbow
 - Obsessive-Compulsive Disorder
 - Skin Disorder, Eczema, Psoriasis
 - Peripheral Neuropathy
 - Major Depression
 - Deafness or Tinnitus
 - Other: Please Specify
 - Coronary Disorder or Heart Attack
 - Migraine Headaches
 - Low Blood Pressure
 - Liver Disease or Hepatitis
 - Back Pain or Sciatica
 - Seizures or Epilepsy
 - Kidney Disorder or Kidney Stones
 - Abdominal Pain
 - Cancer or Tumors
 - Spleen or Lymphatic Disorder
 - Rheumatoid Arthritis
 - Multiple Sclerosis
 - Irritable Bowel Syndrome or Colitis
 - Fibromyalgia
 - Allergies or Hayfever
 - Hypoglycemia
 - Bone Fracture/Joint Sprain
 - Tuberculosis
 - Dysmenorrhea (Painful Menstruation)
 - Carpal Tunnel Syndrome
 - Attention Deficit Disorder
 - Prostate or Vaginal Disorder
 - Frozen Shoulder
 - Panic Attacks or Phobias
 - Raynaud's Disease
 - Shingles (Herpes Zoster)
 - Schizophrenia
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Accidents: Have you ever been injured in any of the following types of accidents?

- Automobile Accident
 - Athletic Injury
 - Other: Please Specify
 - Work Related Accident
 - Surgical Complication
 - Accident at Home
 - Other Accident
-
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Current Conditions: In the past year, have you noticeably experienced any of the following?

- | | |
|--|---|
| <input type="checkbox"/> Pain in Legs or Feet | <input type="checkbox"/> Large Weight Gain or Weight Loss |
| <input type="checkbox"/> Sinus Congestion | <input type="checkbox"/> Pain in Arms, Wrist, Hands |
| <input type="checkbox"/> Overeating or Binge Eating | <input type="checkbox"/> Colds, Flu or Chills |
| <input type="checkbox"/> Cold Hands or Cold Feet | <input type="checkbox"/> Undereating or Poor Appetite |
| <input type="checkbox"/> Sore Throats | <input type="checkbox"/> Swollen Ankles or Feet |
| <input type="checkbox"/> Craving for Sweets or Chocolate | <input type="checkbox"/> Nausea or Vomiting |
| <input type="checkbox"/> Stiff, Aching Joints | <input type="checkbox"/> Craving for Drugs or Alcohol |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Neck or Shoulder Tension |
| <input type="checkbox"/> Dissatisfaction with Job | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Grinding Your Teeth | <input type="checkbox"/> Bored or Uninterested in Things |
| <input type="checkbox"/> Blurred Vision | <input type="checkbox"/> Rapid Heart Beat |
| <input type="checkbox"/> Loneliness or Lack of Affection | <input type="checkbox"/> Lethargy, Fatigue |
| <input type="checkbox"/> Excessive Sweating | <input type="checkbox"/> Sex Life Not Satisfying |
| <input type="checkbox"/> Difficulty Sleeping | <input type="checkbox"/> Hyperventilation |
| <input type="checkbox"/> Thoughts of Killing Yourself | <input type="checkbox"/> Disturbing Dreams |
| <input type="checkbox"/> Dizziness or Fainting | <input type="checkbox"/> Worried About Finances |
| <input type="checkbox"/> Relationship Problems | <input type="checkbox"/> Other: Please Specify |
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Substances or Medications: In the past several months, did you regularly take any of these?

- | | |
|--|---|
| <input type="checkbox"/> Cigarettes or Cigars | <input type="checkbox"/> Aspirin or Tylenol |
| <input type="checkbox"/> Sleeping Pills | <input type="checkbox"/> Several Cups of Coffee/Day |
| <input type="checkbox"/> Prescribed Pain Reliever Medication | <input type="checkbox"/> Anti-Anxiety Pills |
| <input type="checkbox"/> Glass of Beer or Wine | <input type="checkbox"/> Recreational Drugs/Marijuana |
| <input type="checkbox"/> Anti-Depressant Pills | <input type="checkbox"/> Liquor or Mixed Drinks |
| <input type="checkbox"/> Several Cans of Soda/Day | <input type="checkbox"/> Blood Pressure Pills |
| <input type="checkbox"/> Other: Please Specify | |
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Patient or Parent/Guardian Signature