Kelly Murphy Acupuncture & Bodywork

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HEALTH HISTORY

Please help us provide you with a complete evaluation by taking the time to fill out this questionnaire carefully. All of your answers will be held absolutely confidential. If you have questions, please ask. If there is anything you wish to bring to our attention which is not on this form, please note in the comments section. Thank You.

Name:_____ Date:_____

Address:_____

City:_____ State:_____ Zip:_____

Home Phone:_____ Work Phone:_____

Mobile Phone:_____ E-Mail:_____

Marital Status:_____ Date of Birth:_____ Age:_____

Physician:_____ Phone:_____

In Emergency Notify:_____ Phone:_____

Referred By:_____ Occupation:_____

Have you been treated by acupuncture or Oriental medicine before? _____

Main Complaint (symptoms, diagnosis, duration, etc.)_____

_____

_____

What kinds of treatments have you tried?_____

_____

Significant Trauma (physical or emotional)_____

Allergies (chemicals, foods, drugs)_____

_____

Medications (please attach additional pages if necessary)_____

_____

Surgeries (please include date of procedure)_____

_____

Your Birth History (prolonged labor, forceps delivery, etc)_____

Exercise (type of activity, days per week, length of workout)_____

Diet (meals per day, caffeinated drinks, alcohol per week)_____

_____

Personal Medical History Please check any conditions or symptoms you have now.

☐ Cancer	☐ Diabetes	☐ Seizures
☐ Stroke	☐ Heart Disease	☐ Thyroid Disease
☐ Hepatitis	☐ High Blood Pressure	☐ Other_____

Family Medical History Please check any condition that applies to your immediate family.

☐ Cancer	☐ Diabetes	☐ Seizures
☐ Stroke	☐ Heart Disease	☐ High Blood Pressure
☐ Allergies	☐ Asthma	☐ Other_____

Please check if you had any of these items listed below in the last 3 months.

General

☐ Poor Sleeping	☐ Night Sweats	☐ Fatigue
☐ Sweats Easily	☐ Weight Loss	☐ Cravings
☐ Change in Appetite	☐ Weight Gain	☐ Fevers
☐ Sudden Energy Drop	☐ Bleed/Bruise Easily	☐ Poor Appetite
☐ Peculiar Tastes or Smells	☐ Dental problems	☐ Strong Thirst (hot or cold)

Skin and Hair

☐ Rashes	☐ Itching	☐ Hives
☐ Dandruff	☐ Eczema	☐ Acne
☐ Recent Moles	☐ Loss of Hair	☐ Change in skin/hair texture
☐ Warts	☐ Ulcerations	☐ Skin Discoloration

Head, Eyes, Ears, Nose and Throat

☐ Dizziness	☐ Migraines	☐ Eye Pain
☐ Eye Strain	☐ Poor Vision	☐ Cataracts
☐ Blurry Vision	☐ Night Blindness	☐ Color Blindness
☐ Spots in Front of Eyes	☐ Glasses	☐ Ringing in the Ears
☐ Poor Hearing	☐ Grinding Teeth	☐ Facial Pain
☐ Nose Bleeds	☐ Sinus Problems	☐ Earaches
☐ Headaches	☐ Jaw Clicks	☐ Sores on Lips/Tongue
☐ Dental Problems	☐ Recurrent sore throats	☐ Difficulty Swallowing

Cardiovascular

☐ Low Blood Pressure	☐ Chest pain or Pressure	☐ Irregular Heart Beat
☐ Cold Hands/Feet	☐ Palpitations	☐ Varicose/Spider Veins
☐ Swelling of Hands/Feet	☐ Shortness of Breath	☐ Spontaneous Sweating
☐ Blood Clots	☐ Fainting	☐ Phlebitis

Respiratory

☐ Cough/Wheezing	☐ Coughing Blood	☐ Bronchitis
☐ Pneumonia	☐ Asthma	☐ Difficult Breathing
☐ Pain with Deep Inhalation	☐ Production of Phlegm..if so what color?_____	

Gastrointestinal

☐ Nausea	☐ Vomiting	☐ Constipation
☐ Diarrhea	☐ Gas	☐ Belching
☐ Indigestion	☐ Blood in Stools	☐ Black Stools
☐ Rectal Pain	☐ Hemorrhoids	☐ Chronic Laxative Use
☐ Bad Breath	☐ Bloating/Edema	☐ Acid Reflux
☐ Hernia	☐ IBS/Crohn's Disease	☐ Abdominal Pain/Cramps

Genito-Urinary

☐ Pain Upon Urination	☐ Urgency to Urinate	☐ Decrease in Flow
☐ Frequent Urination	☐ Blood in Urine	☐ Sores on Genitals
☐ Kidney Stones	☐ Unable to Hold Urine	☐ Impotence
☐ Decreased Libido	☐ Urinary Tract Infection	☐ Dribbling after Urination
☐ Herpes	☐ Prostatitis	☐ Night Urination

Gynecological/Reproductive

☐ Painful Periods	☐ Vaginal Discharge	☐ Age of first Menses_____
☐ Irregular Menstruation	☐ Ovarian Cysts	☐ Date of last Menses_____
☐ Endometriosis	☐ Infertility	☐ Date of last PAP_____
☐ Vaginal Sores	☐ Vaginal Dryness	☐ Number of Pregnancies__
☐ Polycystic Ovarian Disease	☐ Uterine Fibroids	☐ Number of live Births____
☐ Fibrocystic Breast Tissue	☐Number of Abortions___	☐ Number of Miscarriages__

Musculoskeletal

☐ Back Pain	☐ Knee Pain	☐ Neck Pain
☐ Hip Pain	☐ Shoulder Pain	☐ Sciatica
☐ Bursitis	☐ Sprains/Strains	☐ Muscle Pain
☐ Hand/Wrist Pain	☐ Foot/Ankle Pain	☐ Tendonitis
☐ Carpal Tunnel	☐ Rotator Cuff	☐ Muscle Weakness

Neuropsychological

☐ Seizures	☐ Vertigo/Dizziness	☐ Lack of Coordination
☐ Anxiety/Panic attacks	☐ Loss of Balance	☐ Areas of Numbness
☐ Depression	☐ Poor Memory	☐ Bad Temper/Irritability
☐ ADD?ADHD	☐ Nervousness	☐ Manic Depression
☐ Concussion	☐ Easily Susceptible to Stress	

Have you ever been treated for emotional problems?_____
Have you ever considered or attempted suicide?_____
Have you ever been treated for substance abuse?_____

Comments Please inform us of any other problems you would like to discuss.

_____
_____
_____
_____