

The Medical Spa at Nova Community Acupuncture

HEALTH HISTORY

Date: ___ / ___ / ___

Name:				Sex:		Age:	
Address:				City:		State:	
Phone #1: Home Cell Other		Phone #2: Work Cell Other		Email:			
Date of Birth:		Emergency Contact: (name & relationship)				Phone #:	
Height:		Weight:		Relationship Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Living w/partner <input type="checkbox"/> Other : _____			
Occupation:				Employer:			
How did you hear of our clinic?: <input type="checkbox"/> Word of Mouth <input type="checkbox"/> Internet <input type="checkbox"/> Yellow Pages <input type="checkbox"/> Craigslist <input type="checkbox"/> Flyer <input type="checkbox"/> Walk / Drive by <input type="checkbox"/> Print Ad <input type="checkbox"/> Other : _____				Referred by:			
Physician: _____ Phone #: _____				Have you been treated by Acupuncture or Oriental Medicine Before? <input type="checkbox"/> No <input type="checkbox"/> Yes ___ / ___ / ___			

MAIN COMPLAINTS

Please write in your top 3 health complaints / concerns in order of importance to you. Circle the items that make it better or worse and mark on the scale from 1-10 the severity of the condition (1=no symptoms, 10=worst ever)

1

When did this start? _____ ago

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

1 |-----| 10

2

When did this start? _____ ago

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

1 |-----| 10

3

When did this start? _____ ago

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

1 |-----| 10

HEALTH HISTORY

Circle the ↑ if you have / had the condition and note the year it started.
Circle the fff if there is a family history of the condition.

	YOU	Year	FAMILY		YOU	Year	FAMILY
Cancer type(s)?	↑	_____	fff	Osteoporosis	↑	_____	fff
Diabetes	↑	_____	fff	Herpes	↑	_____	fff
Hepatitis	↑	_____	fff	AIDS / HIV	↑	_____	fff
High Blood Pressure	↑	_____	fff	Other STD	↑	_____	fff
Heart Disease	↑	_____	fff	Rheumatic Fever	↑	_____	fff
Stroke	↑	_____	fff	Alcoholism	↑	_____	fff
Seizure Disorder	↑	_____	fff	Allergies type(s)?	↑	_____	fff
Thyroid Disease	↑	_____	fff	Mental Illness	↑	_____	fff
Asthma	↑	_____	fff	Kidney Disease	↑	_____	fff
Pacemaker	↑	_____	fff	Anemia	↑	_____	fff

HABITS

	Amount / Week	If Quit, Year?
Coffee / Tea	_____	_____
Soda	_____	_____
Tobacco	_____	_____
Alcohol	_____	_____
Drugs	_____	_____

EXERCISE

Do you exercise regularly? Yes No

If so, what and how often:

DIET Do you have a special diet now or in the past? (vegetarian, vegan, raw, Atkins, etc.)
Describe w/ dates: _____

MEDICATIONS

Please note what medications, herbs or supplements that you take regularly

INJURIES & SURGERIES

Please note what happened to what body area and when it occurred (incl. dental)
