

SARANA COMMUNITY ACUPUNCTURE

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Health History Form

Name: \_\_\_\_\_ (first) \_\_\_\_\_ (middle) \_\_\_\_\_ (last)

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

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_ Zip Code \_\_\_\_\_

Phone # (day) \_\_\_\_\_ (evening) \_\_\_\_\_

Email Address \_\_\_\_\_ Referred by \_\_\_\_\_

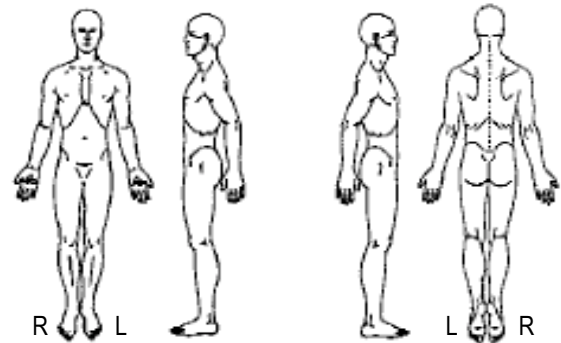
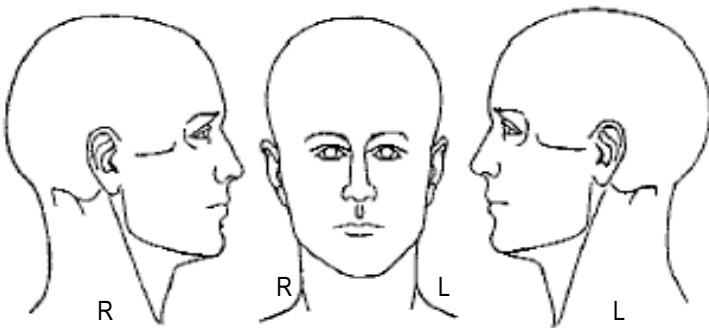
Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_\_ Gender \_\_\_\_\_ Occupation \_\_\_\_\_

Please complete this questionnaire as thoroughly as possible. All of your answers will be held confidential within lawful limits. If you have anything you wish to bring to our attention, which is not asked on this form, please note it in the 'Comments' section. Print all information and indicate areas of confusion with a question mark. Thank you.

Please list the conditions you wish to be treated:

\_\_\_\_\_
\_\_\_\_\_
\_\_\_\_\_
\_\_\_\_\_
\_\_\_\_\_
\_\_\_\_\_
\_\_\_\_\_

Please number the locations on the diagrams where you are feeling any pain:



Pain description (For each location, check all that apply):

Location: chronic/ intermittent severe/ moderate/ mild sharp/ dull

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_

Comments:

\_\_\_\_\_
\_\_\_\_\_
\_\_\_\_\_

(OVER PLEASE)

Please list any medications (prescribed and over-the-counter), herbs, vitamins, and supplements you are currently taking:

Medication/Supplement _____	Purpose: _____
_____	_____
_____	_____
_____	_____
_____	_____

**Current Health: (circle any that currently apply)**

**Temperature:** Fever Chills Night sweats Spontaneous Day sweats Hot Flashes

Do you tend to feel: Warmer than others Cooler than others

**Thirst:** Do you tend to be thirsty? Yes No **Temperature drinks you prefer:** warm room temperature cool cold / iced

**Digestion:** Changes in Appetite Nausea/Vomiting Abdominal Pain Gas Heartburn Belching Other \_\_\_\_\_

**Bowel movements:** Frequency \_\_\_/day \_\_\_/ week Formed Loose Liquid (diarrhea) Strained Incomplete

**Urination:** Dark yellow / Light yellow / Clear Scant / Copious Urgent Frequent Painful Night-time

**Breathing:** Coughing Wheezing Shortness of Breath Other \_\_\_\_\_

**Head, Eye, Ear, Nose, and Throat:** Headaches Eye Pain/Strain Tearing/Dryness Ear Ringing Earaches

Sinus Problems Nose Bleeds Frequent Sore Throats TMJ/Jaw Problems Other \_\_\_\_\_

**Circulation:** Palpitations Cold Extremities High Blood Pressure Chest Pain Swelling of Ankles

Stroke Heart Murmurs Do you have a pacemaker? Yes / No Other \_\_\_\_\_

**Sleep:** Hours per night \_\_\_\_\_ Insomnia Excess sleepiness Frequent / vivid dreams Other \_\_\_\_\_

**Mental State:** Irritability Anxiety Depression Mood Swings Other \_\_\_\_\_

**Energy and Immunity:** Fatigue Slow Wound Healing Chronic Infections Allergies (describe) \_\_\_\_\_

Do you have reduced immunity (such as due to HIV, Hepatitis C, chemotherapy or auto-immune disease)? Yes / No Describe \_\_\_\_\_

**Female Reproductive/Breasts:** Irregular Cycles Breast Lumps/Tenderness Nipple Discharge Heavy Flow

Vaginal Discharge (describe) \_\_\_\_\_ PMS Bleeding Between Periods Painful Periods Other \_\_\_\_\_

**Menstrual/Birthing History:** Age of First Menses: \_\_\_\_\_ # of Days of Menses: \_\_\_\_\_ Length of Cycle: \_\_\_\_\_

Total # of Pregnancies: \_\_\_\_\_ Live births \_\_\_\_\_ Age at onset of Menopause: \_\_\_\_\_ Are you pregnant? Yes / No

**Male Reproductive:** Sexual Difficulties Prostate Problems Testicular Pain/Swelling Penile Discharge Other \_\_\_\_\_

**Neurologic:** Dizziness Paralysis Numbness/Tingling Loss of Balance Seizures/Epilepsy Other \_\_\_\_\_

**Skin:** Rashes Hives Acne Eczema Sores/Wounds Other \_\_\_\_\_

Other concerns that you wish to inform us about – for example: family health history, prior diseases or surgeries: \_\_\_\_\_

Do do you any have any special sensitivities to needling? Describe \_\_\_\_\_