

Grassroots Community Acupuncture

418 N 35th Street, Seattle, WA 98103

(206) 659-4990

Health History Questionnaire and Registration

| Patient Information | Contact Information |
|--|--|
| <p>Date _____</p> <p>Name _____</p> <p>Address _____</p> <p>City, State, Zip _____</p> <p>Age _____ Birthdate _____</p> <p>Occupation _____</p> <p>Company Name _____</p> <p>Primary Physician _____</p> <p>Physician Phone # _____</p> <p>How did you hear about us? _____</p> <p>_____</p> | <p>Home Phone _____</p> <p>Work Phone _____</p> <p>Other/Cell Phone _____</p> <p>Email _____</p> <p>Another person we may contact if needed:</p> <p>Name _____</p> <p>Relationship _____</p> <p>Home Phone _____</p> <p>Work Phone _____</p> |
| Health History | |
| <p>What are your primary concerns for coming in for treatment?</p> <p>1) _____</p> <p>2) _____</p> <p>3) _____</p> <p>How is your sleep? _____</p> <p>_____</p> <p>How is your digestion? _____</p> <p>_____</p> <p>List medications or food supplements you are taking:</p> <p>_____</p> <p>_____</p> <p>List serious illnesses, accidents, or surgeries:</p> <p>_____</p> <p>_____</p> <p>Check illnesses that have occurred in blood relatives:</p> <p><input type="checkbox"/> Diabetes <input type="checkbox"/> High blood pressure <input type="checkbox"/> Stroke</p> <p><input type="checkbox"/> Cancer <input type="checkbox"/> Heart disease <input type="checkbox"/> Kidney disease</p> | <p>Check Symptoms you have or have had in the last year:</p> <ul style="list-style-type: none"><input type="checkbox"/> Depression<input type="checkbox"/> Difficulty in focusing<input type="checkbox"/> Dizziness<input type="checkbox"/> Easily startled<input type="checkbox"/> Excessive worry<input type="checkbox"/> Excessive Anger<input type="checkbox"/> Excessive fear<input type="checkbox"/> Fatigue/tiredness<input type="checkbox"/> Headaches<input type="checkbox"/> Loss of sleep/poor sleep<input type="checkbox"/> Nervousness/irritability<input type="checkbox"/> Overwhelmed by life<input type="checkbox"/> Weight loss/weight gain <p>Check conditions you have or have had in the past:</p> <ul style="list-style-type: none"><input type="checkbox"/> AIDS<input type="checkbox"/> Allergies<input type="checkbox"/> Anemia<input type="checkbox"/> Arthritis<input type="checkbox"/> Bleeding Disorders<input type="checkbox"/> Breast Lump<input type="checkbox"/> Cancer<input type="checkbox"/> Diabetes <p>How long has it been since you have had a complete medical exam? _____</p> <p>_____</p> |

Health History... Continued

Check symptoms you have or have had in the last year:

MUSCLE/JOINT/BONES:

- Tremors
- Cramps
- Swollen Joints

Pain, weakness, numbness in:

- Arms or Hips
- Back
- Legs
- Feet
- Neck
- Hands
- Shoulders
- Other _____

EYES/EARS/NOSE/THROAT/RESPIRATORY:

- Asthma/wheezing
- Blurred or failing vision
- Difficulty breathing
- Earache
- Enlarged glands
- Eye pain
- Frequent colds
- Hay fever
- Hoarseness
- Gum trouble
- Nose bleeds
- Loss of hearing
- Persistent cough
- Ringing in ears
- Sinus problems

SKIN:

- Boils
- Bruise easily
- Dry Skin
- Itching/rash
- Sensitive skin
- Sores that won't heal
- Sweating (unusual i.e. night, easily, etc.)

GENITO-URINARY:

- Blood/pus in urine
- Frequent Urination
- Inability to control urine
- Kidney infection/stones
- Lowered libido

CARDIOVASCULAR:

- Chest pain
- Hardening of arteries
- High or low blood pressure
- Pain over heart
- Poor circulation
- Previous heart attack
- Rapid/irregular heart beat
- Swelling of ankles

GASTROINTESTINAL

- Belching, gas, or bloating
- Colon trouble
- Constipation
- Diarrhea
- Difficulty swallowing
- Distention of abdomen
- Excessive hunger
- Gall bladder trouble
- Hemorrhoids (piles)
- Indigestion
- Nausea
- Pain over stomach
- Poor appetite
- Vomiting

FOR MEN ONLY:

- Erection difficulties
- Penis discharge
- Prostate trouble

FOR WOMEN ONLY:

- Bleeding between periods
- Clots during menstruation
- Excessive menstrual flow
- Extreme menstrual pain
- Irregular cycle
- Menopausal symptoms
- PMS
- Previous miscarriage
- Scanty menstrual flow

Could you be pregnant? _____

Signature

The information on this form is correct to the best of my knowledge.

Signature _____ Date _____