Unity Community Acupuncture — Health History and Intake

Legal Name: _____ Today's Date: _____/_____/_____
first last

What you would like to be called: _____Pronouns:_____Gender Identity:_____

Date of Birth: _____/_____/_____Age: _____Sex Assigned at Birth: _____

Sexual Orientation:_____Relationship status: S M P D W Other

Address _____
city state zip

Phone _____ Alt Phone _____

Email _____ Would you like to be included in our email newsletter? Y or N

Primary Care Provider _____ contact_____

Emergency contact _____
name phone relationship

How did you hear of us? _____

Have you had acupuncture before? Y or N If so, when was your last treatment? _____

Do you have kids? Names & ages: _____

Who do you live with? (Circle all that apply) Spouse/Partner Children Friends Alone Other

What is your profession? _____

What are you seeking treatment for?
How long has this been going on?
What makes it worse? **What makes it better?**

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Have you sought other treatment for this? If so, please list them and their results

Please check any illnesses or conditions you currently have or have had in the past:		
◯ AIDS/HIV	◯ Heart Disease	◯ Pneumonia
◯ Alcoholism	◯ Hepatitis	◯ Polio
◯ Allergies	◯ High Blood Pressure	◯ Rheumatic Fever
◯ Anemia	◯ Infectious Disease	◯ Seizures
◯ Antibiotic Use	◯ Jaundice	◯ Shingles
◯ Asthma	◯ Kidney Disease	◯ STI's
◯ Bleed Easily	◯ Mental/Emotional Disorders	◯ Stroke
◯ Cancer	◯ Multiple Sclerosis	◯ Thyroid Conditions
◯ Chicken Pox	◯ Night Sweats	◯ Tuberculosis
◯ Diabetes	◯ Pertussis/ Whooping Cough	◯ Ulcers
◯ Epilepsy		◯ Vascular disease
◯ Glaucoma		◯ Pacemaker

Have you had any of the following medical tests?		
◯ Cholesterol	Date:	Results:
◯ Hepatitis	Date:	Results:
◯ HIV test:	Date:	Results:
◯ Mammogram:	Date:	Results:
◯ High Blood Pressure	Date:	Results:
◯ Pap Smear	Date:	Results:
◯ Physical	Date:	Results:
◯ Thermography	Date:	Results:
◯ Stool	Date:	Results:

Have you had your appendix removed? Y or N Date:
Have you had your gallbladder removed? Y or N Date:
Have you had ovaries or uterus removed? Y or N Date:
Have you been exposed to antibiotics or steroids? Y or N Date: If so, for what condition(s)?
Were you born prematurely? Y or N How many weeks?

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Have you been Immunized for:		Does your Family have a history of:	
◯ Chicken Pox	◯ MMR (Measles/ Mumps/ Rubella)	◯ Alcoholism	◯ High Blood Pressure
◯ Tdap (Tetanus/ Diphtheria/Pertussis)	◯ Tetanus Only	◯ Allergies	◯ Kidney Disease
◯ Hepatitis	◯ Varicella Only	◯ Bleeding Easily	◯ Mental/Emotional Disorders
◯ HPV (Human Papillomavirus)	◯ Shingles	◯ Cancer	◯ Obesity
◯ Flu	◯ Meningitis	◯ Diabetes	◯ Stroke
	◯ Other _____	◯ Epilepsy	◯ Other _____
		◯ Heart Disease	◯ Unsure of Family History

What medications, vitamins, supplements, homeopathics, herbs, etc., are you taking & what are they for?

Have you had any significant life changes over the past 2 years? Y or N If so, please explain below:

Have you had any recent surgeries, injuries, or traumas?

How much time do you take to relax/unwind & what do you do? Example: meditate, read, exercise, yoga, dance, spiritual/religious practice, etc.

How many hours of sleep do you get a night? _____ What is your sleep like?

What is your diet like? Please include caffeine, soda, and sugar consumption.

Do you smoke, drink alcohol or use recreational drugs? How much/how many per week?

Circle any of the feelings you have experienced in the last few months?		
Abused	Persecuted	Despair
Overwhelmed	Distress	Sad
Agitated	Uncertainty	Restless
Panic	Paralyzed	Outraged
Criticized	Guilty	Helpless
Muddled	Fearful	Grieving
Uneasy	Aggravated	Paranoid
Intolerant	Depressed	Nervous
Overworked	Easily irritated	Hopeless
Anxious	Impatient	Unable to grieve
Intimidated	Annoyed	Apprehensive
Angry	Rejected	Numb
Worried		

Please mark the circle that best describes the level of stress for the below listings.	
My Family stress is:	◯none ◯minimal ◯moderate ◯severe
My relationship stress is:	◯none ◯minimal ◯moderate ◯severe
My work stress is:	◯none ◯minimal ◯moderate ◯severe
My financial stress is:	◯none ◯minimal ◯moderate ◯severe
My health stress is:	◯none ◯minimal ◯moderate ◯severe
Other _____	◯none ◯minimal ◯moderate ◯severe
Other _____	◯none ◯minimal ◯moderate ◯severe
Other _____	◯none ◯minimal ◯moderate ◯severe

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For those who identify as (Women, Transgender, Nonbinary, Genderqueer, Gender Fluid, Two Spirit) and menstruate/d	Are you Pregnant? Y or N	If yes, when is your due date?
Date of Last Menses?	Number of Days bleeding?	Age of First Menses?
# of Days between Start of one cycle to start of the next?		
Do you have pain or cramping? Y or N or Occasionally Where/When?		
Flow: Heavy / Normal / Light Flow Color?		
Is there clotting? Y or N If so, what color and size?		
PMS Symptoms: (Mark all that apply) ◯ Irritable ◯ Mood Swings ◯ Crying ◯ Breast Tenderness ◯ Breast Pain ◯ Breast Masses ◯ Nipple Discharge ◯ Fatigue ◯ Headaches/Migraines ◯ Acne flare-ups ◯ Food cravings _____		
# of Pregnancies: # of Births: # of Miscarriages: # of Abortions:		
Vaginal Discharge? Y or N or Sometimes Do you have a history of yeast infections?		
Menopause: Age at onset?	Hot Flashes? Y or N or Occ.	Night Sweats? Y or N or Occ.
Libido Level?		

For those who identify as (Men, Transgender, Nonbinary, Genderqueer, Gender Fluid, Two Spirit)
Prostate Health? ◯◯ Fine ◯ Poor ◯ Unknown ◯ Prior History of Prostate issues? _____
Sexual Dysfunction: ◯◯ Yes ◯ No ◯ Sometimes
◯ Prostatitis ◯ Hernia ◯ Testicular Masses ◯ Testicular Sensitivity/Pain ◯ Vasectomy
Libido Level:

The above information is true and accurate to the best of my knowledge and I agree to update my practitioner of any changes.

Signature _____ Date _____