



# PRESCOTT COMMUNITY ACUPUNCTURE

634 Schemmer Drive, Suite 202 Prescott, AZ 86305

928-713-0071 [www.prescottacupuncture.com](http://www.prescottacupuncture.com)

## 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 number _____</p> <p>How did you hear about us? _____</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>How is your digestion? _____</p> <p>List medications or food supplements you are taking.</p> <p>_____</p> <p>List serious illnesses, accidents or surgeries.</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"> <li><input type="checkbox"/> Depression</li> <li><input type="checkbox"/> Difficulty in focusing</li> <li><input type="checkbox"/> Dizziness</li> <li><input type="checkbox"/> Easily startled</li> <li><input type="checkbox"/> Excessive worry</li> <li><input type="checkbox"/> Excessive anger</li> <li><input type="checkbox"/> Excessive fear</li> <li><input type="checkbox"/> Fatigue/tiredness</li> <li><input type="checkbox"/> Headaches</li> <li><input type="checkbox"/> Loss of sleep/poor sleep</li> <li><input type="checkbox"/> Loss or gain of weight</li> <li><input type="checkbox"/> Nervousness/irritability</li> <li><input type="checkbox"/> Overwhelmed by life</li> </ul> <p>Check conditions you have or have had in the past:</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> AIDS</li> <li><input type="checkbox"/> Allergies</li> <li><input type="checkbox"/> Anemia</li> <li><input type="checkbox"/> Arthritis</li> <li><input type="checkbox"/> Bleeding disorders</li> <li><input type="checkbox"/> Breast lump</li> <li><input type="checkbox"/> Cancer</li> <li><input type="checkbox"/> Diabetes</li> </ul> <p>How long has it been since you have had a complete medical exam? _____</p>

**HEALTH HISTORY...CONTINUED**

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

**MUSCLE/JOINT/BONES**

- Tremors c Cramps
- Swollen joints

Pain, weakness, numbness in:

- Arms or Hips
- Back Legs
- Feet
- Neck
- Hands
- Shoulders
- Other \_\_\_\_\_

**EYES/EAR/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
- Sore won't heal
- Sweats

**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 in menses
- 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 \_\_\_\_\_