



NEW PATIENT HEALTH HISTORY

Thank you for your interest in BiaoHealth Acupuncture.

Please be so kind to fill out this entire health history form to the best of your ability. All information obtained in this history document can be extremely helpful to assist you in realizing your optimal health and wellness goals.

PATIENT INFORMATION			
Today's Date:		Gender:	
Patient's Last Name:		First:	Middle:
Alias/Maiden Name:		Preferred name:	
Street Address:		Social Security no.:	
City:		State:	ZIP Code:
Home Phone: ():	Cell Phone: ():	May BiaoHealth call and leave a message? <input type="checkbox"/> YES <input type="checkbox"/> NO	
Other Phone: ():	Email Address:	May BiaoHealth send you emails about clinic events or newsletters? <input type="checkbox"/> YES <input type="checkbox"/> NO	
<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Domestic partnership <input type="checkbox"/> Other _____			
My Sexual Orientations:		Spouse/Domestic partner's Name:	
EMERGENCY CONTACT			
Emergency Contact:		Relationship:	
Emergency Contact Phone: ()	Emergency Contact Office/Cell Phone: ()		
PRIMARY CARE PROVIDER			
Provider's Name:		Provider's Phone: ():	
Provider's Address:		Date of last visit:	
If you do not have a primary care provider, are you interested in establishing a primary care?			
EMPLOYMENT			
I am currently: <input type="checkbox"/> Full Time <input type="checkbox"/> Part-time <input type="checkbox"/> Self employed <input type="checkbox"/> Student <input type="checkbox"/> Unemployed <input type="checkbox"/> Retired			
Job Title / Description:		Number of hours of work/study per week:	
Employer Name:		Employer Phone: ()	
Employer Address:			

GENERAL HEALTH

Chief Complaint: What is the primary concern associated with your visit today?

Onset: How long have you had this/these issues?

Does anything make the condition better? YES NO If yes, what?

Does anything make the condition worse? YES NO If yes, what?

Have you been treated for this condition before? YES NO If yes, please describe.

Are you currently being treated for any other medical problems? YES NO If yes, please describe.

Are there any other issues or health concerns you are hoping to work on?

Have you tried acupuncture before? YES NO If yes, please describe.

How did you hear about the clinic?
 Website Another Health Care Provider Advertisement Friend _____ Other _____

MEDICATIONS

Do you have allergies to medications: YES NO If yes, please describe:

List Pharmaceuticals, both prescription and over-the-counter, that you are currently taking:

List all herbal prescriptions and supplements you are taking:

DIET AND NUTRITION-Please describe a typical daily diet in your life.

Breakfast:

Lunch

Dinner

Snacks?

RISK FACTOR SCREENING

Please describe your past and current usage of the following substances:

				Comments
past	current			
<input type="checkbox"/>	<input type="checkbox"/>	Caffeine	_____ cups per day	_____
<input type="checkbox"/>	<input type="checkbox"/>	Tobacco	_____ cigarettes per day/week	_____
<input type="checkbox"/>	<input type="checkbox"/>	Alcohol	_____ drinks per day/week	_____
<input type="checkbox"/>	<input type="checkbox"/>	Marijuana	_____ use per day/week	_____
<input type="checkbox"/>	<input type="checkbox"/>	Crack	_____ use per day/week	_____
<input type="checkbox"/>	<input type="checkbox"/>	Cocaine	_____ use per day/week	_____
<input type="checkbox"/>	<input type="checkbox"/>	Meth	_____ use per day/week	_____
<input type="checkbox"/>	<input type="checkbox"/>	Heroin	_____ use per day/week	_____
<input type="checkbox"/>	<input type="checkbox"/>	Other	_____ use per day/week	_____

SIGNS AND SYMPTOMS

Check the "past" box next to any symptoms you have experienced in the past.
Check the "current" box next to any symptoms you are currently experiencing.

<p>General past current</p> <ul style="list-style-type: none"> Insomnia Dreams/nightmares Cold hands/feet Chills Fever Night sweats Decreased ability to taste or smell Sweet taste in mouth Metallic taste in mouth Crave spicy foods Crave sweets Crave salty foods Crave sour foods Crave bitter foods Often feel sad Often feel afraid Often feel angry Usually feel happy Irritability Depression Anxiety Mood swings Fatigue Often worried Indecisiveness Poor memory Other _____ <p>Neurological past current</p> <ul style="list-style-type: none"> Seizures Tremors Numbness or tingling Paralysis Other _____ 	<p>Head and Neck past current</p> <ul style="list-style-type: none"> Headaches Migraines Stiff neck Dizziness Fainting Swollen glands Other _____ <p>Eyes past current</p> <ul style="list-style-type: none"> Corrective lenses Blurred vision Poor night vision Spots or floaters Eye inflammation Dryness Tearing Glaucoma Cataracts Other _____ <p>Ears past current</p> <ul style="list-style-type: none"> Ear ringing Hearing loss Infections Ear ache Vertigo Other _____ <p>Nose, Throat, Mouth past current</p> <ul style="list-style-type: none"> Sinus infections Allergies Dry throat Feeling of something stuck in throat Sore throat Difficulty swallowing Bad breath Bleeding gums Grinding teeth Nasal congestion Nosebleeds Loss of voice Other _____ 	<p>Respiratory past current</p> <ul style="list-style-type: none"> Difficulty breathing with exertion Difficulty breathing when lying down Wheezing Asthma Chronic cough Wet cough Cough with phlegm Cough with blood Other _____ <p>Cardiovascular past current</p> <ul style="list-style-type: none"> High blood pressure Low blood pressure Chest pain or tightness Palpitations Rapid heart beat Poor circulation Swollen ankles Anemia Other _____ <p>Gastrointestinal past current</p> <ul style="list-style-type: none"> Nausea Vomiting Acid reflux/GERD Stomach pain Abdominal bloating Indigestion Poor appetite Change in appetite Gas: Belching Gas: Flatulence Diarrhea Constipation Dry/hard stool Blood in stool Hemorrhoids Jaundice Liver disorder Gall bladder disorder Other _____
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SIGNS AND SYMPTOMS- CONTINUED

Check the "past" box next to any symptoms you have experienced in the past.
Check the "current" box next to any symptoms you are currently experiencing.

<p>Skin past current</p> <ul style="list-style-type: none"> Hives Rashes Eczema Psoriasis Dry skin Easy bruising Changes in moles Itching Measles Chicken-pox Shingles Acne Other _____ <p>Musculoskeletal past current</p> <ul style="list-style-type: none"> Joint pain Weak muscles sore/weak knees/ankles Difficulty walking Neck/shoulder pain Upper/mid back pain Lower back pain Rib pain Limited range of motion muscle spasms/twitches Other _____ 	<p>Genito-Urinary past current</p> <ul style="list-style-type: none"> Frequent urination Painful urination Urgent urination Blood in urine Unable to hold urine Incomplete urination Bedwetting Wake to urinate Kidney stone Increased sex drive Decreased sex drive Pain/itching of genitalia Genital lesions/discharge Infertility Other _____ 	<p>Female specific past current</p> <ul style="list-style-type: none"> Frequent urinary tract infections Frequent vaginal infections Pelvic inflammatory disease Abnormal PAP smear Irregular periods Premenstrual syndrome Painful menstrual bleeding Abnormal bleeding Menopause symptoms Breast lumps Other _____ <p>Male specific past current</p> <ul style="list-style-type: none"> Premature ejaculation Testicular lumps Prostatitis Impotence Other _____ <p>Infection screening (check if you have been tested, circle positive (+) if you have the condition)</p> <p>tested</p> <ul style="list-style-type: none"> HIV (+) TB (+) Hepatitis A/B/C (+) HPV (+) Gonorrhea (+) Chlamydia (+) Syphilis (+) Genital warts (+) Herpes: oral/genital (+)
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FAMILY HEALTH HISTORY- place an x where applicable					
	Self	Mother	Father	Sibling	Sibling
Allergies (environmental)					
Asthma					
Blood Disorder					
Anemia					
Diabetes (type I or type II)					
Cancer (type:)					
COPD/Emphysema					
Headaches					
Migraines					
Seizures					
High Blood Pressure/Hypertension					
High Cholesterol					
Heart Problem (type:)					
Heart Attack					
Stroke					
Kidney Disorder					
Bladder Disorder					
Stomach/Intestinal Disorder					
Constipation					
Diarrhea					
Thyroid Disorder					
Drug/Alcohol Abuse					
Tuberculosis					
Hepatitis (type:)					
HIV/AIDS					
Sexually Transmitted Infection (type:)					
Autoimmune Disease (type:)					
Depression					
Anxiety / Panic Attacks					
Other					
Other					
Other					
Age at Death					
Comments:					

FEMALE REPRODUCTIVE HEALTH			
Age of first menstruation:	First day of last menses:	Duration of flow (# of days):	Clots: (yes, no)
Color of Blood:	Number of days in cycle (21, 28, 33, etc):	Consistency (thin, thick):	
PMS: <input type="checkbox"/> Pain <input type="checkbox"/> Cramps <input type="checkbox"/> Breast Tenderness <input type="checkbox"/> Other _____			
Current method of contraception:		Contraception History:	
Have you ever been pregnant? <input type="checkbox"/> yes <input type="checkbox"/> no	Are you trying to get pregnant? <input type="checkbox"/> yes <input type="checkbox"/> no	Are you currently pregnant? <input type="checkbox"/> yes <input type="checkbox"/> no	Due Date:
Date of menopause:	Hormone Replacement Therapy? <input type="checkbox"/> yes <input type="checkbox"/> no	I understand that I must notify my BiaoHealth practitioner if/when I become pregnant. _____ (initial and date)	

SEXUAL ACTIVITY		
Are you sexually active? <input type="checkbox"/> yes <input type="checkbox"/> no	Number of current or recent sexual partners:	Do you currently practice safe sex? <input type="checkbox"/> yes <input type="checkbox"/> no

PRIOR HOSPITALIZATIONS OR SURGERIES	
Year:	Operation/Condition:
Year:	Operation/Condition:
Year:	Operation/Condition:

ADDITIONAL INFORMATION
Do you currently have an exercise regiment? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, please describe.
Do you currently have a spiritual practice? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, please describe.
Please provide any additional information about yourself or your condition not covered by the above questions.