



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? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, what?	
Does anything make the condition worse? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, what?	
Have you been treated for this condition before? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, please describe.	
Are you currently being treated for any other medical problems? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, please describe.	
Are there any other issues or health concerns you are hoping to work on?	
Have you tried acupuncture before? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, please describe.	
How did you hear about the clinic? <input type="checkbox"/> Website <input type="checkbox"/> Another Health Care Provider <input type="checkbox"/> Advertisement <input type="checkbox"/> Friend _____ <input type="checkbox"/> 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><b>General</b></p> <p>past    current</p> <p><input type="checkbox"/>    <input type="checkbox"/> Insomnia</p> <p><input type="checkbox"/>    <input type="checkbox"/> Dreams/nightmares</p> <p><input type="checkbox"/>    <input type="checkbox"/> Cold hands/feet</p> <p><input type="checkbox"/>    <input type="checkbox"/> Chills</p> <p><input type="checkbox"/>    <input type="checkbox"/> Fever</p> <p><input type="checkbox"/>    <input type="checkbox"/> Night sweats</p> <p><input type="checkbox"/>    <input type="checkbox"/> Decreased ability to taste or smell</p> <p><input type="checkbox"/>    <input type="checkbox"/> Sweet taste in mouth</p> <p><input type="checkbox"/>    <input type="checkbox"/> Metallic taste in mouth</p> <p><input type="checkbox"/>    <input type="checkbox"/> Crave spicy foods</p> <p><input type="checkbox"/>    <input type="checkbox"/> Crave sweets</p> <p><input type="checkbox"/>    <input type="checkbox"/> Crave salty foods</p> <p><input type="checkbox"/>    <input type="checkbox"/> Crave sour foods</p> <p><input type="checkbox"/>    <input type="checkbox"/> Crave bitter foods</p> <p><input type="checkbox"/>    <input type="checkbox"/> Often feel sad</p> <p><input type="checkbox"/>    <input type="checkbox"/> Often feel afraid</p> <p><input type="checkbox"/>    <input type="checkbox"/> Often feel angry</p> <p><input type="checkbox"/>    <input type="checkbox"/> Usually feel happy</p> <p><input type="checkbox"/>    <input type="checkbox"/> Irritability</p> <p><input type="checkbox"/>    <input type="checkbox"/> Depression</p> <p><input type="checkbox"/>    <input type="checkbox"/> Anxiety</p> <p><input type="checkbox"/>    <input type="checkbox"/> Mood swings</p> <p><input type="checkbox"/>    <input type="checkbox"/> Fatigue</p> <p><input type="checkbox"/>    <input type="checkbox"/> Often worried</p> <p><input type="checkbox"/>    <input type="checkbox"/> Indecisiveness</p> <p><input type="checkbox"/>    <input type="checkbox"/> Poor memory</p> <p><input type="checkbox"/>    <input type="checkbox"/> Other _____</p> <p><b>Neurological</b></p> <p>past    current</p> <p><input type="checkbox"/>    <input type="checkbox"/> Seizures</p> <p><input type="checkbox"/>    <input type="checkbox"/> Tremors</p> <p><input type="checkbox"/>    <input type="checkbox"/> Numbness or tingling</p> <p><input type="checkbox"/>    <input type="checkbox"/> Paralysis</p> <p><input type="checkbox"/>    <input type="checkbox"/> Other _____</p>	<p><b>Head and Neck</b></p> <p>past    current</p> <p><input type="checkbox"/>    <input type="checkbox"/> Headaches</p> <p><input type="checkbox"/>    <input type="checkbox"/> Migraines</p> <p><input type="checkbox"/>    <input type="checkbox"/> Stiff neck</p> <p><input type="checkbox"/>    <input type="checkbox"/> Dizziness</p> <p><input type="checkbox"/>    <input type="checkbox"/> Fainting</p> <p><input type="checkbox"/>    <input type="checkbox"/> Swollen glands</p> <p><input type="checkbox"/>    <input type="checkbox"/> Other _____</p> <p><b>Eyes</b></p> <p>past    current</p> <p><input type="checkbox"/>    <input type="checkbox"/> Corrective lenses</p> <p><input type="checkbox"/>    <input type="checkbox"/> Blurred vision</p> <p><input type="checkbox"/>    <input type="checkbox"/> Poor night vision</p> <p><input type="checkbox"/>    <input type="checkbox"/> Spots or floaters</p> <p><input type="checkbox"/>    <input type="checkbox"/> Eye inflammation</p> <p><input type="checkbox"/>    <input type="checkbox"/> Dryness</p> <p><input type="checkbox"/>    <input type="checkbox"/> Tearing</p> <p><input type="checkbox"/>    <input type="checkbox"/> Glaucoma</p> <p><input type="checkbox"/>    <input type="checkbox"/> Cataracts</p> <p><input type="checkbox"/>    <input type="checkbox"/> Other _____</p> <p><b>Ears</b></p> <p>past    current</p> <p><input type="checkbox"/>    <input type="checkbox"/> Ear ringing</p> <p><input type="checkbox"/>    <input type="checkbox"/> Hearing loss</p> <p><input type="checkbox"/>    <input type="checkbox"/> Infections</p> <p><input type="checkbox"/>    <input type="checkbox"/> Ear ache</p> <p><input type="checkbox"/>    <input type="checkbox"/> Vertigo</p> <p><input type="checkbox"/>    <input type="checkbox"/> Other _____</p> <p><b>Nose, Throat, Mouth</b></p> <p>past    current</p> <p><input type="checkbox"/>    <input type="checkbox"/> Sinus infections</p> <p><input type="checkbox"/>    <input type="checkbox"/> Allergies</p> <p><input type="checkbox"/>    <input type="checkbox"/> Dry throat</p> <p><input type="checkbox"/>    <input type="checkbox"/> Feeling of something stuck in throat</p> <p><input type="checkbox"/>    <input type="checkbox"/> Sore throat</p> <p><input type="checkbox"/>    <input type="checkbox"/> Difficulty swallowing</p> <p><input type="checkbox"/>    <input type="checkbox"/> Bad breath</p> <p><input type="checkbox"/>    <input type="checkbox"/> Bleeding gums</p> <p><input type="checkbox"/>    <input type="checkbox"/> Grinding teeth</p> <p><input type="checkbox"/>    <input type="checkbox"/> Nasal congestion</p> <p><input type="checkbox"/>    <input type="checkbox"/> Nosebleeds</p> <p><input type="checkbox"/>    <input type="checkbox"/> Loss of voice</p> <p><input type="checkbox"/>    <input type="checkbox"/> Other _____</p>	<p><b>Respiratory</b></p> <p>past    current</p> <p><input type="checkbox"/>    <input type="checkbox"/> Difficulty breathing with exertion</p> <p><input type="checkbox"/>    <input type="checkbox"/> Difficulty breathing when lying down</p> <p><input type="checkbox"/>    <input type="checkbox"/> Wheezing</p> <p><input type="checkbox"/>    <input type="checkbox"/> Asthma</p> <p><input type="checkbox"/>    <input type="checkbox"/> Chronic cough</p> <p><input type="checkbox"/>    <input type="checkbox"/> Wet cough</p> <p><input type="checkbox"/>    <input type="checkbox"/> Cough with phlegm</p> <p><input type="checkbox"/>    <input type="checkbox"/> Cough with blood</p> <p><input type="checkbox"/>    <input type="checkbox"/> Other _____</p> <p><b>Cardiovascular</b></p> <p>past    current</p> <p><input type="checkbox"/>    <input type="checkbox"/> High blood pressure</p> <p><input type="checkbox"/>    <input type="checkbox"/> Low blood pressure</p> <p><input type="checkbox"/>    <input type="checkbox"/> Chest pain or tightness</p> <p><input type="checkbox"/>    <input type="checkbox"/> Palpitations</p> <p><input type="checkbox"/>    <input type="checkbox"/> Rapid heart beat</p> <p><input type="checkbox"/>    <input type="checkbox"/> Poor circulation</p> <p><input type="checkbox"/>    <input type="checkbox"/> Swollen ankles</p> <p><input type="checkbox"/>    <input type="checkbox"/> Anemia</p> <p><input type="checkbox"/>    <input type="checkbox"/> Other _____</p> <p><b>Gastrointestinal</b></p> <p>past    current</p> <p><input type="checkbox"/>    <input type="checkbox"/> Nausea</p> <p><input type="checkbox"/>    <input type="checkbox"/> Vomiting</p> <p><input type="checkbox"/>    <input type="checkbox"/> Acid reflux/GERD</p> <p><input type="checkbox"/>    <input type="checkbox"/> Stomach pain</p> <p><input type="checkbox"/>    <input type="checkbox"/> Abdominal bloating</p> <p><input type="checkbox"/>    <input type="checkbox"/> Indigestion</p> <p><input type="checkbox"/>    <input type="checkbox"/> Poor appetite</p> <p><input type="checkbox"/>    <input type="checkbox"/> Change in appetite</p> <p><input type="checkbox"/>    <input type="checkbox"/> Gas: Belching</p> <p><input type="checkbox"/>    <input type="checkbox"/> Gas: Flatulence</p> <p><input type="checkbox"/>    <input type="checkbox"/> Diarrhea</p> <p><input type="checkbox"/>    <input type="checkbox"/> Constipation</p> <p><input type="checkbox"/>    <input type="checkbox"/> Dry/hard stool</p> <p><input type="checkbox"/>    <input type="checkbox"/> Blood in stool</p> <p><input type="checkbox"/>    <input type="checkbox"/> Hemorrhoids</p> <p><input type="checkbox"/>    <input type="checkbox"/> Jaundice</p> <p><input type="checkbox"/>    <input type="checkbox"/> Liver disorder</p> <p><input type="checkbox"/>    <input type="checkbox"/> Gall bladder disorder</p> <p><input type="checkbox"/>    <input type="checkbox"/> Other _____</p>

**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><b>Skin</b> past current</p> <p><input type="checkbox"/> <input type="checkbox"/> Hives</p> <p><input type="checkbox"/> <input type="checkbox"/> Rashes</p> <p><input type="checkbox"/> <input type="checkbox"/> Eczema</p> <p><input type="checkbox"/> <input type="checkbox"/> Psoriasis</p> <p><input type="checkbox"/> <input type="checkbox"/> Dry skin</p> <p><input type="checkbox"/> <input type="checkbox"/> Easy bruising</p> <p><input type="checkbox"/> <input type="checkbox"/> Changes in moles</p> <p><input type="checkbox"/> <input type="checkbox"/> Itching</p> <p><input type="checkbox"/> <input type="checkbox"/> Measles</p> <p><input type="checkbox"/> <input type="checkbox"/> Chicken-pox</p> <p><input type="checkbox"/> <input type="checkbox"/> Shingles</p> <p><input type="checkbox"/> <input type="checkbox"/> Acne</p> <p><input type="checkbox"/> <input type="checkbox"/> Other _____</p> <p><b>Musculoskeletal</b> past current</p> <p><input type="checkbox"/> <input type="checkbox"/> Joint pain</p> <p><input type="checkbox"/> <input type="checkbox"/> Weak muscles</p> <p><input type="checkbox"/> <input type="checkbox"/> sore/weak knees/ankles</p> <p><input type="checkbox"/> <input type="checkbox"/> Difficulty walking</p> <p><input type="checkbox"/> <input type="checkbox"/> Neck/shoulder pain</p> <p><input type="checkbox"/> <input type="checkbox"/> Upper/mid back pain</p> <p><input type="checkbox"/> <input type="checkbox"/> Lower back pain</p> <p><input type="checkbox"/> <input type="checkbox"/> Rib pain</p> <p><input type="checkbox"/> <input type="checkbox"/> Limited range of motion</p> <p><input type="checkbox"/> <input type="checkbox"/> muscle spasms/twitches</p> <p><input type="checkbox"/> <input type="checkbox"/> Other _____</p>	<p><b>Genito-Urinary</b> past current</p> <p><input type="checkbox"/> <input type="checkbox"/> Frequent urination</p> <p><input type="checkbox"/> <input type="checkbox"/> Painful urination</p> <p><input type="checkbox"/> <input type="checkbox"/> Urgent urination</p> <p><input type="checkbox"/> <input type="checkbox"/> Blood in urine</p> <p><input type="checkbox"/> <input type="checkbox"/> Unable to hold urine</p> <p><input type="checkbox"/> <input type="checkbox"/> Incomplete urination</p> <p><input type="checkbox"/> <input type="checkbox"/> Bedwetting</p> <p><input type="checkbox"/> <input type="checkbox"/> Wake to urinate</p> <p><input type="checkbox"/> <input type="checkbox"/> Kidney stone</p> <p><input type="checkbox"/> <input type="checkbox"/> Increased sex drive</p> <p><input type="checkbox"/> <input type="checkbox"/> Decreased sex drive</p> <p><input type="checkbox"/> <input type="checkbox"/> Pain/itching of genitalia</p> <p><input type="checkbox"/> <input type="checkbox"/> Genital lesions/discharge</p> <p><input type="checkbox"/> <input type="checkbox"/> Infertility</p> <p><input type="checkbox"/> <input type="checkbox"/> Other _____</p>	<p><b>Female specific</b> past current</p> <p><input type="checkbox"/> <input type="checkbox"/> Frequent urinary tract infections</p> <p><input type="checkbox"/> <input type="checkbox"/> Frequent vaginal infections</p> <p><input type="checkbox"/> <input type="checkbox"/> Pelvic inflammatory disease</p> <p><input type="checkbox"/> <input type="checkbox"/> Abnormal PAP smear</p> <p><input type="checkbox"/> <input type="checkbox"/> Irregular periods</p> <p><input type="checkbox"/> <input type="checkbox"/> Premenstrual syndrome</p> <p><input type="checkbox"/> <input type="checkbox"/> Painful menstrual bleeding</p> <p><input type="checkbox"/> <input type="checkbox"/> Abnormal bleeding</p> <p><input type="checkbox"/> <input type="checkbox"/> Menopause symptoms</p> <p><input type="checkbox"/> <input type="checkbox"/> Breast lumps</p> <p><input type="checkbox"/> <input type="checkbox"/> Other _____</p> <p><b>Male specific</b> past current</p> <p><input type="checkbox"/> <input type="checkbox"/> Premature ejaculation</p> <p><input type="checkbox"/> <input type="checkbox"/> Testicular lumps</p> <p><input type="checkbox"/> <input type="checkbox"/> Prostatitis</p> <p><input type="checkbox"/> <input type="checkbox"/> Impotence</p> <p><input type="checkbox"/> <input type="checkbox"/> Other _____</p> <p><b>Infection screening</b> (check <input type="checkbox"/> if you have been tested, circle positive (+) if you have the condition)</p> <p>tested</p> <p><input type="checkbox"/> HIV (+)</p> <p><input type="checkbox"/> TB (+)</p> <p><input type="checkbox"/> Hepatitis A/B/C (+)</p> <p><input type="checkbox"/> HPV (+)</p> <p><input type="checkbox"/> Gonorrhea (+)</p> <p><input type="checkbox"/> Chlamydia (+)</p> <p><input type="checkbox"/> Syphilis (+)</p> <p><input type="checkbox"/> Genital warts (+)</p> <p><input type="checkbox"/> Herpes: oral/genital (+)</p>
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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.