HEALING SPACE
HEALTH CENTER

Personal Information

Date: _____ **Sex:** ☐ M ☐ F **Date of Birth:** ___/___/_____

Name: _____ **Phone:** _____

Address: _____ **Zip:** _____

Email: _____

Marital Status: ☐ Single ☐ Married/Partnership ☐ Divorced ☐ Separated ☐ Widowed

Occupation: _____ **Employer Name:** _____

Emergency Contact: _____ **Phone:** _____

Have you had acupuncture before? ☐ Yes ☐ No

Please, describe condition(s) for which treatment is sought:

1. _____

Date of onset of symptom(s): _____ **Severity of symptoms 1-10 (1 mild / 10 severe** _____

Have you seen your physician about this condition? ☐ Yes ☐ No

2. _____

Date of onset of symptom(s): _____ **Severity of symptoms 1-10 (1 mild / 10 severe** _____

Have you seen your physician about this condition? ☐ Yes ☐ No

3. _____

Date of onset of symptom(s): _____ **Severity of symptoms 1-10 (1 mild / 10 severe** _____

Have you seen your physician about this condition? ☐ Yes ☐ No

Please indicate if ANY of the following applies to you:

☐ Hemophiliac	☐ Anticoagulant use	☐ Epilepsy	☐ Diabetes
☐ Pacemaker	☐ Stroke/CVA	☐ Vegetarian/Vegan	☐ Hepatitis
☐ Heart condition	☐ HIV/AIDS	☐ Lung condition	☐ Cancer

Are you pregnant/Is there a chance that you are pregnant? ☐ Yes ☐ No

General

☐ Cold hands/feet	☐ Always feel hot	☐ Always feel cold
☐ Fever&chills	☐ Unexplained weight changes	☐ Fatigue

Please list tested or suspected allergies and related symptoms:

Foods _____ Seasonal _____

Drugs/Other _____

Cardiovascular:

☐ Heart palpitations	☐ Chest pain/tightness	☐ Poor circulation
☐ Irregular heartbeat	☐ Swelling feet/ankles	☐ Varicose veins

☐ Other _____

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Genital/Urinary:

- ☐ Pain/Itching of genitalia
- ☐ Frequent urination
- ☐ Urgent urination
- ☐ Bedwetting
- ☐ Increased libido
- ☐ Kidney stone
- ☐ Genital lesions/discharge
- ☐ Excessive or scant urination
- ☐ Unable to hold urine
- ☐ Other _____
- ☐ Painful/burning urination
- ☐ Blood in urine
- ☐ Nighttime urination
- ☐ Decreased libido

Muscles&Joints:

- ☐ Joint pain
- ☐ "Heaviness" of body/limbs
- ☐ Joint discoloration
- ☐ Body aches/stiffness
- ☐ Joint swelling
- ☐ Other _____
- ☐ General weakness
- ☐ Numbness/tingling

Skin:

- ☐ Hives/rashes
- ☐ Itchy skin
- ☐ Bruise easily
- ☐ Changes in moles/lumps
- ☐ Acne
- ☐ Spontaneous sweat
- ☐ Brittle/weak nails
- ☐ Other _____
- ☐ Dry skin
- ☐ Eczema/psoriasis
- ☐ Night sweats

Gastrointestinal:

- ☐ Nausea
- ☐ Hiccups
- ☐ Constipation
- ☐ Blood in stool
- ☐ **Blood in stool**
- ☐ Acid reflux/heartburn
- ☐ Other _____
- ☐ Vomiting
- ☐ Bloating
- ☐ Anal fissures
- ☐ Hemorrhoids
- ☐ **Laxative use**
- ☐ Alternating diarrhea/constipation
- ☐ Black stool
- ☐ Gas
- ☐ Bad breath
- ☐ Mucous in stool
- ☐ Intestinal pain/cramping

Appetite/Thirst:

- ☐ Exceedingly hungry
- ☐ Specific cravings
- ☐ t° of drinks most commonly desired ☐ Very cold ☐ Tepid ☐ Very hot
- ☐ Other _____
- ☐ Poor appetite
- ☐ Excessive thirst
- ☐ Hunger w/no desire to eat
- ☐ Thirst w/no desire to drink
- ☐ No thirst

Sleep:

- ☐ Sound/restful
- ☐ Wake easily/early
- ☐ Difficulty waking up
- ☐ Trouble falling asleep
- ☐ Dream disturbed
- # of hours of sleep per night _____
- ☐ Trouble staying asleep
- ☐ Vivid dreaming/nightmares
- ☐ Other _____

Emotions:

- ☐ Relaxed/calm
- ☐ Impatient
- ☐ Anxious
- ☐ Other _____
- ☐ Sad/grief/depressed
- ☐ Angry/frustrated
- ☐ Stressed
- ☐ Fearful
- ☐ Forgetfu;/poor memory
- ☐ Manic

Menses:

Age at first Menses: _____
Cycle length _____
Number of pregnancies _____
Number of births _____

Please list all the medications you are currently taking and what they are for:

_____
_____
_____

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