ACUPUNCTURE
HEALTH HISTORY FORM

For Your Information:
An accurate health history is important to ensure that it is safe for you to receive a treatment. If your health status changes in the future, please let us now. All information gathered for this treatment is confidential except as required or allowed by law or to facilitate diagnosis (assessment) or treatment. You will be asked to provide written authorization for release of any information.

Name: ____ Preferred Name (if any): ______________

Address: ____ Today's Date: _________

City: ____________________________ Postal Code: ________________

Telephone Number (Home): __________________________ (Work): _______________________
(Cell):_____________________

E-mail Address: ____

Date of Birth: ________________/_______________/________________
Month Day Year

Primary Care Physician: _______________________________________ Address: _______________________

Occupation: ____

What is your **primary complaint?** (The reason you are coming to our office today)
____
____

Have you gone for any x-rays, ultrasounds, MRI's etc. for ***this injury/problem?*** YES / NO

If YES, where? _______________________________________ and approximately when? _____________

Present Involvement in Other Healthcare: YES (please specify) ___________________________

Current Medications:
____

Surgeries (Nature/Date):
____

Major Injuries (Nature/Date):
____

Of Special Note (presence of internal pins, wires, artificial joints, special equipment, etc.):

How did you learn about Binbrook Family Chiropractic?

☐ Referral from doctor / Friend/ Patient / Other (Name):
____

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Personal History Check the conditions/symptoms you have or have had.

- ◻ Arthritis
- ◻ High/low blood pressure
- ◻ Cancer
- ◻ Ulcer
- ◻ Chronic fatigue
- ◻ Alcoholism
- ◻ Gastritis/Pancreatitis
- ◻ Liver/Gall bladder disease
- ◻ Hypo/hyperglycemia
- ◻ Diabetes
- ◻ Seizures
- ◻ Anemia
- ◻ Lyme disease
- ◻ Asthma
- ◻ Stroke
- ◻ Kidney disease
- ◻ Food allergies/intolerance
- ◻ Hepatitis
- ◻ Thyroid imbalance
- ◻ Chronic pain
- ◻ Infertility
- ◻ Heart disease
- ◻ High cholesterol
- ◻ IBS/diverticulitis
- ◻ Raynaud's disease
- ◻ Respiratory allergies
- ◻ Impotence
- ◻ Emphysema

Family Medical History Check any that apply to your immediate family

- ◻ Diabetes
- ◻ High blood pressure
- ◻ Seizures
- ◻ Allergies
- ◻ Heart Disease
- ◻ Cancer
- ◻ Stroke
- ◻ Asthma
- ◻ Other

General Symptoms Check if you have had any of these in the last three months

- ◻ Poor/strong appetite
- ◻ Strongly like cold/hot drinks
- ◻ Muscle weakness/fatigue
- ◻ Poor sleep
- ◻ Dental/gum problems
- ◻ Bodily heaviness
- ◻ Weight loss/gain
- ◻ Sudden energy drop
- ◻ Fatigue
- ◻ Sweat easily
- ◻ Poor Balance
- ◻ Peculiar tastes/smells
- ◻ Change in appetite
- ◻ Fever
- ◻ Night sweats
- ◻ Cold hands/feet
- ◻ Tremors
- ◻ Bleeding/bruising easily

Skin and Hair Check all that apply

- ◻ Rashes
- ◻ Eczema/Psoriasis
- ◻ Skin discoloration
- ◻ Dermatitis
- ◻ Ulcerations
- ◻ Dandruff
- ◻ Acne
- ◻ Warts
- ◻ Hives/allergic dermatitis
- ◻ Hair loss
- ◻ Change in hair texture
- ◻ Fungal infections
- ◻ Itching
- ◻ Recent moles
- ◻ Face flushing

Head, Eyes, Ears, Nose and Throat Check all that apply

- ◻ Eye strain
- ◻ Eye pain
- ◻ Colour blindness
- ◻ Cataracts
- ◻ Poor vision
- ◻ Spots in front of eyes
- ◻ Ringing in ears
- ◻ Poor hearing
- ◻ Earaches
- ◻ Recurrent sore throat/cold
- ◻ Dental problems
- ◻ Migraines/headache

Head, Eyes, Ears, Nose and Throat cont'

- ◻ Difficulty swallowing
- ◻ Grinding teeth
- ◻ Sores on lips/tongue
- ◻ Nose bleeds
- ◻ Sinus problems
- ◻ Facial pain
- ◻ Jaw clicks/locks
- ◻ Dizziness
- ◻ Blurred vision

Cardiovascular Check all that apply

- ◻ Chest pain or pressure
- ◻ High/low blood pressure
- ◻ Irregular heart beat
- ◻ Swelling of hands/feet
- ◻ Varicose/spider veins
- ◻ Spontaneous sweating
- ◻ Palpitations at rest
- ◻ Blood clots
- ◻ Pressure in chest
- ◻ Dizziness/Fainting
- ◻ Phlebitis
- ◻ Shortness of breath

Respiratory Check all that apply

- ◻ Cough/wheezing
- ◻ Pneumonia
- ◻ Coughing blood
- ◻ Pain with deep inhalation
- ◻ Asthma
- ◻ Tightness in chest
- ◻ Bronchitis
- ◻ Difficult inhale/exhale
- ◻ Difficult breathing lying down
- ◻ Production of phlegm

Gastrointestinal Check all that apply

- ◻ Nausea
- ◻ Gas
- ◻ Indigestion
- ◻ Bloating/edema
- ◻ Changes in appetite
- ◻ Vomiting
- ◻ Belching
- ◻ Bad breath
- ◻ Chronic laxative use
- ◻ Acid reflux/GERD
- ◻ Significant thirst
- ◻ Diarrhea
- ◻ Blood/mucous in stool
- ◻ Rectal pain
- ◻ Loose stool
- ◻ Hernia
- ◻ IBS/Crohn's disease
- ◻ Constipation
- ◻ Hemorrhoids
- ◻ Abdominal pain/cramps

Genito-Urinary Check all that apply

- ◻ Pain during urination
- ◻ Unable to hold urine
- ◻ Urgent urination
- ◻ Burning urination
- ◻ Urinary tract infection
- ◻ Night urination
- ◻ Frequent urination
- ◻ Kidney stones
- ◻ Sores on genitals
- ◻ Decreased libido
- ◻ Pain in testicles
- ◻ Blood in urine
- ◻ Scanty/copious urine flow
- ◻ Prostatitis
- ◻ Herpes
- ◻ Impotence
- ◻ Nocturnal emission
- ◻ Premature ejaculation
- ◻ Dribbling after urination
- ◻ Infections

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Gynecological/Reproductive Check all that apply

- ☐ Difficult/painful intercourse
- ☐ Vaginal dryness
- ☐ Vaginal sores
- ☐ Vaginal discharge
- ☐ Infertility
- ☐ Irregular menstruation
- ☐ Ovarian cysts
- ☐ Endometriosis
- ☐ Uterine fibroids
- ☐ Fibrocystic breast tissue
- ☐ Polycystic Ovarian Syndrome
- ☐ PMD
- ☐ Painful menstruation

If you practice birth control… For how long?__________ What type?_________________

Age of first menses______________
Date of last menses______________
Date of last PAP/Pelvic____________
Number of Pregnancies___________
Number of ectopic pregnancies_____
Number of live births_____________
Number of miscarriages____________
Number of abortions______________

Musculoskeletal Check all that apply

- ☐ Neck pain
- ☐ Shoulder pain
- ☐ Hip pain
- ☐ Back pain
- ☐ Knee pain
- ☐ Hand/wrist pain
- ☐ Foot/ankle pain
- ☐ Muscle weakness
- ☐ Limited range of motion
- ☐ Sprains/strains
- ☐ Muscle pain
- ☐ Sciatica
- ☐ Bursitis
- ☐ Carpal tunnel
- ☐ Tendonitis
- ☐ Rotator cuff

Neuropsychological Check all that apply

- ☐ Seizures
- ☐ Lack of coordination
- ☐ Anxiety/panic attacks
- ☐ Nervousness
- ☐ Depression
- ☐ Seasonal affective disorder
- ☐ Bad temper/ irritation
- ☐ Considered/ attempted suicide
- ☐ Seeing a therapist
- ☐ ADD/ADHD
- ☐ Easily stressed
- ☐ Poor memory
- ☐ Areas of numbness

If there are any other issues or problems that you would like to discuss please list in the space below:
____
____
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____
____

Signature___________________________________