

Outermost Community Acupuncture

Health History and Registration

PATIENT INFORMATION

Date _____

Name _____

Preferred Name or

Nickname _____

Address _____

City State Zip _____

Age _____ Birthdate _____

Occupation _____

Primary Physician _____

How did you hear about OMCA? _____

CONTACT INFORMATION

Home phone _____

Work phone _____

Other/cell phone _____

Email _____

Another person we may contact if needed:

Name _____

Relationship _____

Home phone _____

Work phone _____

HEALTH HISTORY

What are your primary concerns for coming in for treatment?

1- _____

2 - _____

3 - _____

How is your sleep? _____

How is your digestion? _____

List medications or food supplements you are taking. _____

List serious illnesses, accidents or surgeries.

Circle illnesses that have occurred in blood relatives:

Diabetes High Blood Pressure Stroke
Cancer Heart Disease Kidney Disease

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

Depression
Difficulty in focusing
Dizziness
Easily startled
Excessive worry
Excessive anger
Excessive fear
Fatigue/tiredness
Headaches
Loss of sleep/poor sleep
Loss or gain of weight
Nervousness/irritability
Overwhelmed by life

Circle conditions you have or have had in the past:

AIDS
Allergies
Anemia
Arthritis
Bleeding disorders
Breast lump
Cancer
Diabetes

How long has it been since you have had a complete medical exam? _____

HEALTH HISTORY...CONTINUED

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

MUSCLE/JOINT/BONES

Tremors or Cramps Swollen joints

Pain, weakness, numbness in:

Arms or Hips

Back Legs

Feet

Neck

Hands

Shoulders

Other _____

EYES/EAR/NOSE/THROAT/BREATHING

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 _____