Enso Acupuncture Health History Form

Thank you for choosing Enso Acupuncture!!! I look forward to working with you.

Classical acupuncture is a holistic system of medicine acknowledging the interrelationships between body mind and spirit. Please answer the following questions to the best of your ability, even if they do not directly apply to your health concern. By doing so, I can create the most effective treatment plan.

New Patient Information Date: _______ /_______ /______________

Mr./ Mrs./ Ms./ Miss/ Dr./ Other: ________________ Surname: ______________________________

Given Name: ______________________________ Preferred Name: ______________________________

Address: ____

Suburb: ____________________________ Post Code: __________ Phone: ________________________

Email: ____

Occupation: ________________________________ Weight: ______________ Height: ______________

Sex: ☐ Male ☐ Female Other: ________________ Are you pregnant? ☐ No ☐ Yes ☐ Possibly

Emergency contact name: ________________________________ Ph: ________________________

Do you have private health care? ☐ No ☐ Yes, provider: ________________________________

Referred by: ☐ Family ☐ Friend ☐ Advert ☐ Internet ☐ Clinic sign Other: ______________

Have you had acupuncture before? ☐ No ☐ Yes Did your condition improve? ☐ No ☐ Yes

Major Complaint

Primary reason for your visit today? ____

____

____

Has a physician diagnosed it? ☐ No ☐ Yes, diagnosis: ________________________________

Are you currently being treated for this condition? ☐ No ☐ Yes, what is the treatment? ___________

____

Has the treatment helped? ☐ Not at all ☐ Not much ☐ Somewhat ☐ Yes

How long have you had this condition? ____

Assessment Questionnaire

Please tick ☑ if you are currently experiencing a symptom

Please write the letter p for past symptoms

Qi, Blood, Yin, Yang

- ☐ anxiety
- ☐ catch colds easily / frequently
- ☐ chest pain traveling to shoulder
- ☐ cold feet
- ☐ cold hands
- ☐ difficult to concentrate
- ☐ dizziness
- ☐ dream disturbed sleep
- ☐ dry skin
- ☐ fatigue
- ☐ feel better after exercise
- ☐ feverish in afternoon or flushed
- ☐ general weakness
- ☐ heat sensation in hands, feet and chest
- ☐ insomnia
- ☐ mental confusion
- ☐ night sweats
- ☐ palpitations
- ☐ poor memory
- ☐ restlessness
- ☐ sores on tip of tongue
- ☐ speech problems
- ☐ sweats easily
- ☐ thirst at night
- ☐ weak voice
- ☐ you feel worse after exercise
- ☐ you see floating black spots

KI / BL

- ☐ frequent urination
- ☐ hair loss
- ☐ joint pain
- ☐ lack of bladder control
- ☐ loose teeth
- ☐ lower back pain
- ☐ memory problems
- ☐ night blindness or low vision
- ☐ ringing in your ears
- ☐ sore, cold or weak knees
- ☐ you get up more than one time at night to urinate

SP

- ☐ belching
- ☐ abdominal bloating and/or gas after eating
- ☐ diarrhea
- ☐ eating disorders
- ☐ fatigue after eating
- ☐ frontal headache
- ☐ general feeling of heaviness in your body or head
- ☐ hard to stop bleeding once started
- ☐ hemorrhoids
- ☐ loose stools
- ☐ low appetite
- ☐ nausea
- ☐ organ prolapse
- ☐ swollen feet/ankles
- ☐ swollen hands
- ☐ week feeling in limbs

HT / PC

- ☐ chest pain
- ☐ dream disturbed sleep
- ☐ high blood pressure
- ☐ insomnia
- ☐ low blood pressure
- ☐ palpitations
- ☐ varicose veins

LU

- ☐ allergies
- ☐ difficulty breathing
- ☐ chills alternating fever
- ☐ cough
- ☐ dry mouth, throat, nose
- ☐ feeling achy
- ☐ headaches
- ☐ nasal discharge
- ☐ nose bleed
- ☐ shortness of breath
- ☐ sinus congestion
- ☐ sneezing
- ☐ sore throat
- ☐ stiff neck/shoulders

ST

- ☐ bad breath
- ☐ belching
- ☐ bleeding, swollen or painful gums
- ☐ burning sensation after eating
- ☐ constipation
- ☐ heartburn
- ☐ large appetite
- ☐ mouth sores (canker or cold sores)
- ☐ stomach pain
- ☐ vomiting

LR / GB

- ☐ abdominal bloating
- ☐ bitter taste in mouth
- ☐ bloating in lower abdomen
- ☐ blurred vision
- ☐ chest pain
- ☐ constipation
- ☐ diarrhea alternating with constipation
- ☐ difficult swallowing
- ☐ discomfort and /or pain around rib area
- ☐ dizziness or vertigo
- ☐ dry eyes
- ☐ emotional irritability, anger easily or depression
- ☐ feeling of a lump in the throat
- ☐ headache at the top of the head
- ☐ high pitched tinnitus
- ☐ muscle spasms, twitching, and/or cramping
- ☐ numbness of hands and feet
- ☐ red and /or sore irritated eyes
- ☐ seizures/ convulsions
- ☐ skin rashes
- ☐ tight feeling in chest
- ☐ lock jaw

Which of these colors are you most drawn to?

green	red	yellow	white	black
☐	☐	☐	☐	☐

Personal Health/History Questionnaire

Your general health as a child was? ☐ Excellent ☐ Good ☐ Average ☐ Poor

Did you feel safe and nurtured as a child? ☐ Always ☐ Usually ☐ Sometimes ☐ Never

Did you have childhood illnesses? ____________________

Please tick ☑ all illnesses or conditions that you currently have or have had in the past:

☐ AIDs/HIV	☐ Emphysema	☐ Lyme Disease
☐ Alcoholism	☐ Epilepsy	☐ Measles
☐ Allergies	☐ Food Allergies	☐ Meningitis
☐ Anemia	☐ Food Intolerance	☐ Mental illness
☐ Antibiotic Use	☐ Gastritis/Pancreatitis	☐ MS
☐ Arthritis	☐ Glaucoma	☐ Mumps
☐ Asthma	☐ Heart Disease	☐ Obesity
☐ Bleeding tendency	☐ Hepatitis	☐ Pneumonia
☐ Cancer	☐ High Blood Pressure	☐ Polio
☐ Chicken Pox	☐ High Cholesterol	☐ Raynaud's Disease
☐ Chronic Fatigue	☐ Hyperthyroid	☐ Respiratory Allergies
☐ Chronic Pain	☐ Hypothyroid	☐ Rheumatic fever
☐ Colitis	☐ IBS	☐ Sexual Disease
☐ Crohn's disease	☐ Impotence	☐ Stroke
☐ Depression	☐ Infertility	☐ Tuberculosis
☐ Diabetes	☐ Jaundice	☐ Typhoid Fever
☐ Drug Abuse	☐ Kidney Disease	☐ Ulcers
☐ Eating Disorder	☐ Liver/Gall B Disease	☐ Vascular Disease

☐ Other____________________

Are you a smoker? ☐ No ☐ Yes If yes, how many per day? ____________________

Do you have a pacemaker? ☐ No ☐ Yes Do you have Seizures? ☐ No ☐ Yes

Do you currently have any infectious diseases? ☐ No ☐ Possibly ☐ Yes, please identify:

☐ HIV/AIDs ☐ Hepatitis C ☐ Hepatitis B ☐ Flu/Cold ☐ Tuberculosis

☐ Streptococcus ☐ Mononucleosis ☐ Other: ____________________

Known or suspected allergies: ____________________

Have you had previous fractures? ☐ No ☐ Yes, locations and dates: ____________________

____

Have you had previous surgery? ☐ No ☐ Yes, for what and dates: ______________________________

____

Have you had a motor vehicle or other significant accident or trauma? ☐ No ☐ Yes

If so, symptoms and dates: ____

____

Medications currently taken including supplements: ______________________________

____

Family History

Please tick ☑ all illnesses or conditions that your family currently have or have had in the past:

- ☐ Alcoholism
- ☐ Allergies
- ☐ Arthritis / Rheumatism
- ☐ Asthma
- ☐ Bleeding Tendency
- ☐ Cancer
- ☐ Colitis / Crohn's disease
- ☐ Depression
- ☐ Diabetes
- ☐ Drug Abuse
- ☐ Epilepsy
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ Kidney disease
- ☐ Mental illness
- ☐ Obesity
- ☐ Stroke
- ☐ Stomach Ulcers
- ☐ Vascular Disease

☐ Other ____

____

Women Only

Are you pregnant? ☐ No ☐ Trying ☐ Possibly ☐ Yes, how many months? __________

Do you use birth control? ☐ No ☐ Yes, what method? ______________________________

Number of: Pregnancies: ________ Births: ________ Miscarriages: ________ Abortions: ________

Please tick ☑ all that apply to you:

- ☐ Scanty Flow
- ☐ Heavy Flow
- ☐ Clotting
- ☐ Vaginal Discharge
- ☐ Abnormal Pap Smear
- ☐ Menopausal Symptoms
- ☐ Premenstrual Problems
- ☐ Painful Periods
- ☐ Breast Tenderness
- ☐ Breast Lumps
- ☐ Nipple Discharge
- ☐ Fibrocystic Breasts
- ☐ Bleeding Between Cycles
- ☐ Irregular Cycles
- ☐ Low Libido
- ☐ Excessive Libido
- ☐ Painful Intercourse
- ☐ Infertility
- ☐ Fibroids
- ☐ Endometriosis
- ☐ Ovarian Cysts

☐ Other ____

Age of first menses: ______ Date of last menses: _____ /_____ /________ Age of menopause: ________

Typical length of menses (days you bleed): ______________________________________

Typical length of cycle (from the 1st day of one cycle to 1st day of the next): ______________________________

Hysterectomy? ☐ Yes ☐ Partial ☐ Complete, date ____ ☐ No

Men Only

Please tick ☑ all that apply to you:

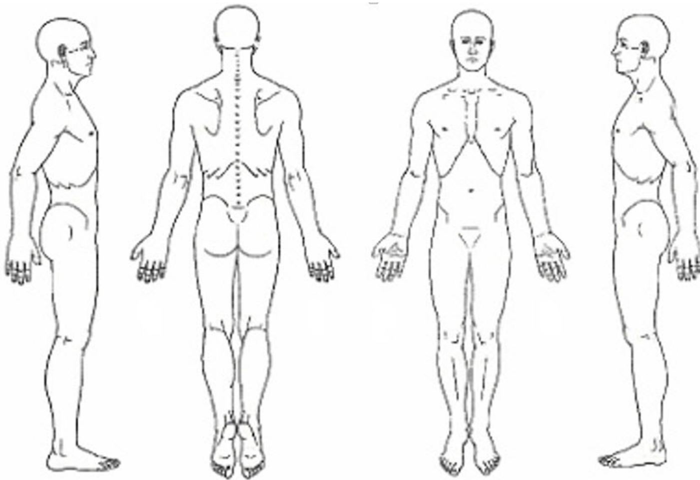
☐ Low Libido	☐ Premature Ejaculation	☐ Testicular Redness
☐ Excessive Libido	☐ Painful Intercourse	☐ Testicular Swelling
☐ Impotence	☐ Prostate Problems	☐ Vasectomy, date:
☐ Seminal Emissions	☐ Testicular Pain	_____/_____/___________

☐ Other ____

Pain

Please answer the following questions if you have pain

Indicate on the diagram your areas of pain:



How long have you had this pain? _______________

____

Describe the onset of your pain? _______________

____

____

____

____

____

On a scale of 1-10 how strong is your pain? (no pain) 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10 (extreme)

What does your pain feel like? (tick all that apply):

☐ Dull	☐ Sharp	☐ Stabbing	☐ Achy	☐ Sore/ Numb	☐ Cramping	☐ Burning
☐ Deep	☐ Superficial	☐ Constant	☐ Fixed	☐ Moves about	☐ Comes and Goes	

Does the pain radiate? ☐ No ☐ Yes, where? ____

What helps the pain?

☐ Ice	☐ Heat	☐ Rest	☐ Movement	☐ Pressure
☐ Moisture	☐ Massage	☐ Nothing	☐ Other: ______________________________	

What aggravates the pain?

☐ Ice	☐ Heat	☐ Rest	☐ Movement	☐ Pressure
☐ Moisture	☐ Massage	☐ Nothing	☐ Other: ______________________________	

Does anything relieve this pain? (i.e.; medications, over the counter drugs, liniments): ____________________

____

Other treatments you have had for this pain? ____

____

Additional Information

Anything you wish to add? ____

____

____

Patient Declaration

The above information is true to the best of my knowledge.

Patient's Signature: ____

Date: _______ /_______ /____________

Office Use Only