

*******BROOKLYN ACUPUNCTURE PROJECT PLLC*******
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Health History Successful health care and preventative medicine are only possible when the practitioner has a complete understanding of the patient physically, mentally and emotionally. Please complete this questionnaire as thoroughly as possible. Print all information and indicate areas of confusion with a question mark. Thank you.

*Name: _____ Date: ____/____/____

Phone Number: _____ email: _____

Address _____

Date of Birth: ____/____/____ Age: _____

How did you hear about us? _____

Who to call in case of emergency (name and number) _____

***What are you here today to address?**

1. _____ 2. _____ 3. _____

***Please circle all conditions you are currently experiencing and underline all you have experienced in the past.**

Energy and Immunity: Fatigue Frequent Colds Chronic Infections Low tolerance to either heat or cold Allergies

Head, Eye, Ear, Nose, and Throat: Eye Pain/Strain Glaucoma Glasses/Contacts Tearing/Dryness Impaired Hearing

Ear Ringing Earaches Headaches Sinus Problems Nose Bleeds Frequent Sore Throats Teeth Grinding

TMJ/Jaw Problems Hay Fever Sensitivity to heat or cold

Respiratory: Pneumonia Bronchitis Difficulty Breathing Emphysema Persistent Cough Asthma Tuberculosis

Shortness of Breath Tightness in the Chest Post Nasal Drip

Cardiovascular: Heart Disease Chest Pain Swelling of Ankles High Blood Pressure

Palpitations/Fluttering Stroke Heart Murmurs Rheumatic Fever Varicose Veins

Gastrointestinal: Ulcers Changes in Appetite Nausea/Vomiting Epigastric Pain Passing Gas Heartburn

Diarrhea Constipation Bloating Belching Gall Bladder Disease Liver Disease Hepatitis B or C Hemorrhoids

Abdominal Pain **Genito-Urinary Tract** Kidney Disease Painful Urination Frequent Infections Frequent Urination

Kidney Stones Impaired Urination Blood in Urine Frequent Urination at Night

Please Print name here _____

Emotional: Mood Swings Nervousness Feelings of Depression Feelings of Anxiety Mental Tension Poor Memory

Female Reproductive/Breasts

Irregular Cycles	Breast Lumps/Tenderness	Nipple Discharge	Heavy Flow
Vaginal Discharge	Premenstrual Problems	Clotting	Bleeding Between Cycles
Menopausal Symptoms	Difficulty Conceiving	Painful Periods	Libido too high/low

Menstrual/Birthing History:

1. Age of First Menses: _____	4. Birth Control Type: _____	7. # of Abortions: _____
2. # of Days of Menses: _____	5. # of Pregnancies: _____	8. # of Live Births: _____
3. Length of Cycle: _____	6. # of Miscarriages: _____	

Male Reproductive:

Sexual Difficulties Prostrate Problems Testicular Pain/Swelling Penile Discharge Libido too high/low

Musculoskeletal:

Neck/Shoulder Pain Muscle Spasms/Cramps Arm Pain Upper Back Pain Mid Back Pain
Low Back Pain Leg Pain Joint Pain (if so, where?): _____.

Neurological: Vertigo/Dizziness Paralysis Numbness/Tingling Loss of Balance Seizures/Epilepsy

Endocrine: Hypothyroid Hypoglycemia Hyperthyroid Diabetes Mellitus Night Sweats Feeling Hot or Cold

Skin and Hair: Acne Rashes Fungus Dry Skin Oily Skin Dry Hair Oily Hair

Lifestyle: How many meals do you eat a day? _____ Do you cook? _____ What is your favorite food? _____

What do you do for exercise? _____

Do you have a Spiritual practice? _____

How many hours per night do you sleep? _____ Do you wake rested? Y N

Occupation: _____ Do you enjoy work? Y N

Alcohol/Caffeine/Tobacco Use: _____

Have you experienced any major traumas? Y N

Have you ever been hospitalized? Y N If so, when and for what _____

Do you have any allergies? Y N If so, to what? _____

What kind of diseases run in your family? _____

Please list any medications including supplements and herbal medicine you are currently taking:

*****Thank You, Enjoy your treatments!*****