Contemporary Acupuncture 33 N. Waukegan Road, Suite 4 Lake Bluff, IL 60044

PATIENT HEALTH HISTORY

Name: (Last) (First) (Initial) Date: / /

D.O.B: / / Age: Gender: M / F Marital Status: S M D W

Address: City: State/Zip:

Phone: Email:

Referred by: Have You Ever Had Acupuncture Treatments Y / N

Emergency Contact: Phone:

1. When, Where, and Why did you last receive healthcare?

2. Please identify the health concerns that have brought you to "Contemporary Acupuncture"

3. Please list any medications, vitamins, and supplements you are currently taking

4. Do you suffer from any of the following conditions? (circle)

Mood Swings	Chronic Fatigue	Nose Bleeds	Headaches
TMJ / Jaw discomfort	Tinnitus	Difficulty Breathing	Common Cold
Heart Disease	Chest Pain	High Blood Pressure	Stroke
Heart Burn	Abdominal Pain	Kidney Disease	Frequent Urination
Irregular Menses	Menopausal Syndrome	Painful Periods	Sexual Difficulties
Prostate Problems	Neck/Shoulder Pain	Arm Pain	Leg Pain
Low Back Pain	Mid Back Pain	Upper Back Pain	Joint Pain
Knee Pain	Dizziness	Night Sweats	Diabetes Mellitus
Anemia	Cancer	Rashes	Cold Hands/Feet

5. Lifestyle Questions:

Do You Take Supplements? Y / N If So, What Brand? _____

Do You Exercise? Y / N If So, What Is Your Routine? _____

How Many Hours Per Night Do You Sleep? _____ Do You Wake Rested? Y / N

Nicotine / Alcohol / Caffeine Use? _____

Height:_____ Weight:_____ Blood Pressure:_____\ _____ Body Temp:_____*F

Please indicate emotions in general: _____

PAIN CHART

Please indicate all areas of pain by filling in the area and placing a number 1-10 to indicate the level of pain as indicated at the bottom of the page.