Rutherford Family Acupuncture

108 E 1st St, Rutherfordton, NC
RutherfordFamilyAcupuncture.com
(828) 375-0076

MEDICAL HISTORY

THIS INFORMATION IS CONFIDENTIAL.

Name _____ **Date** _____

Street Address _____

City _____ **State/Zip**_____

Home Phone_____ **Cell Phone**_____ Preferred: □ Home □ Cell

May we leave confidential voicemails at these numbers? □ Yes □ No

E-mail _____

Age _____ **Date of Birth** _____ **Gender**_____

Marital Status: □ Married □ Never Married □ Widowed □ Divorced or Separated

Occupation:_____ **Retired:** ____ **Disabled:** ____**Unemployed:** ____

Primary Care Physician: _____

How did you hear about us?: _____

Emergency Contact:_____ **Emergency Contact Relation to you:** _____

Emergency Contact telephone:_____ **E-mail** _____

Have you ever been treated by acupuncture or Oriental medicine before? □ Yes □ No

Main Problem you would like us to help you with:_____

_____

_____

_____

_____

How long ago did this problem begin? *Please be specific*: _____

_____

_____

Have you been given a diagnosis for this problem? If so, what diagnosis and by whom?

_____

What other kinds of treatment have you tried? ☐ Western Medicine ☐ Acupuncture ☐ Herbs ☐ Massage ☐ Physical Therapy ☐ Chiropractic ☐ Other:_____

How confident are you that Acupuncture and Chinese herbal medicine will be able to resolve the symptoms of your main complaint?

☐ Not confident ☐ Slightly confident ☐ Moderately confident ☐ Confident ☐ Very confident

Secondary Complaints you would like us to help you with:

1) _____

2) _____

3) _____

Medicines taken within the last two months (vitamins, drugs, herbs, etc.): _____

_____

_____

_____

Hospitalizations/Surgeries (including dates):_____

_____

_____

S**ignificant Trauma (auto accidents, falls, etc.**): _____

_____

Allergies (drugs, chemicals, metals, foods): _____

_____

Do you have a pacemaker, ICD, artificial joint, or other medical implant? □ Yes □ No

If yes, please elaborate:_____

Please note any problems that occurred during your mother's pregnancy and your birth: _____

_____

Were you delivered by Cesarean? □ Yes □ No **If so, was it a planned Cesarean?** □ Yes □ No

Please note any significant information about your vaccination history (e.g., reactions to vaccines, unusual vaccinations, etc.): _____

_____

Please note any childhood or adolescent illnesses, surgeries, accidents: _____

_____

_____

Please note location of all scars and tattoos (e.g., operation or injury scars, <u>even minor ones)</u> _____

_____

_____

_____

.....

Do you follow any type of special diet (e.g. vegetarian, vegan, medical related, or other)? □ Yes □ No

If Yes, what type of diet? _____

Do you smoke? □ Yes □ No **If Yes, how many cigarettes or cigars per day?** _____

Do you use another form of tobacco? □ Yes □ No

Do you use cannabis? □ Yes □ No

How many cups of caffeinated coffee, tea, or cola do you drink per day? _____

How many 8 oz. glasses of water do you drink per day? _____

How many alcoholic beverages do you drink per *week*? _____

Do you drink diet soda or use any zero-calorie sweeteners *(including stevia)* □ Yes □ No

Please describe any use of drugs for non-medical purposes: _____

_____

FOR WOMEN:

Are you pregnant? □ Yes □ No **Is it possible that you are pregnant?** □ Yes □ No

Number of pregnancies: _____ Live births: _____ Miscarriages: _____ Premature births: _____

Age at first menstruation: _____ **Duration of menses:** _____ **Time period between menses:** _____

Do you practice birth control? □ Yes □ No If yes, what type? _____ How long? _____

Symptom List

Circle any problem, disease, or symptom you have now. Underline items that affected you in the past.

Skin: eczema acne skin rashes dermatitis furuncles (boils) fungal infections warts psoriasis hives other skin:_____

Heart and vascular: fast pulse (over 100 beats / min.) slow pulse (less than 60 beats / min.) palpitations irregular pulse feeling of pressure in the chest chest pain cold hands / cold feet Raynaud's disease flushed face high blood pressure low blood pressure anemia cold sweats red face feel dizzy or faint when standing up quickly or standing for a long time stroke heart attack bleed or bruise easily other heart and vascular:_____

Gastrointestinal: constipation diarrhea no appetite excessive appetite stomach pain indigestion heartburn intestinal gas belching ulcer gastritis lack of stomach acid hemorrhoids rectal itching peritonitis pancreatitis irritable bowel polyps GI tumors chronic laxative use nausea eating disorder food craving other gastrointestinal:_____

Respiratory: asthma bronchitis emphysema COPD cough wheeze pneumonia lung abscess other respiratory:_____

Hormonal imbalance: low thyroid overactive thyroid diabetes hypoglycemia pre-diabetes / blood sugar issues other hormone imbalance:_____

Male: impotence premature ejaculation prostate gland problem vasectomy infertility testicular pain venereal disease kidney stones incontinence pain on urination other male:_____

Female: menstrual problems cramping heavy / light / irregular periods PMS emotional reactions menopause symptoms tubal ligation infertility low libido venereal disease discharge kidney stones incontinence pain on urination other female:_____

Head/ENT: deafness tinnitus (ringing in the ear) itchy ear ear pain frequent ear infections excessive earwax sinus headaches yellow mucus stuffy nose post-nasal drip dry throat itchy throat constant sinus congestion nosebleeds bleeding gums periodontitis (gum disease) dental abscess mumps stomatitis (inflammation of the mouth) TMJ toothaches without cavities many cavities degradation of enamel sores on lips, tongue, or mouth bad breath dizziness migraine headache with nausea facial pain other head/ENT:_____

Autoimmune and inflammatory conditions: Hashimoto's disease (thyroid) rheumatoid arthritis systemic lupus erythematosus ulcerative colitis Crohn's disease alopecia (baldness) allergy food allergy sinus allergy atopic dermatitis cellulitis vulvitis low immunity rheumatic disease rheumatic fever arthritis myofascial pain syndrome fibromyalgia tendinitis ligaments RSD/CRPS pericarditis constant slight fever glomerulonephritis plantar fasciitis scarlet fever ear infections swollen glands streptococci infections staphylococci infections easily catch cold other autoimmune and inflammatory:_____

General: difficulty falling asleep difficulty staying asleep difficulty concentrating on a task exhaustion emotional problems (angry, irritable, depressed, anxious) easily get car sick, sea sick, or air sick poor memory no appetite for breakfast moody in mornings unusual sweating (palm, sole, or elsewhere) never sweat night sweats No energy, feel spacey, scattered minded long shower or bath makes you feel dizzy or faint other general:_____

Other: cancer seizures HIV positive hepatitis gallstones other:_____