Finish Line Acupuncture

Community Acupuncture Health Assessment

Note: Information provided on this form is confidential. Please take time to thoughtfully and honestly answer these questions in order to better your healing process.

Name: _____ Date of Birth: _____

Emergency Contact: _____ Phone #:_____ Relation: _____

Address: _____

City: _____ State: _____ Zip:_____

Primary Phone #: _____ Secondary #: _____

Email Address: _____

A 24-hour cancellation notification is required. You may be charged for your appointment for a cancellation made with less than 24 hours' notice.

Please initial that you have read and understand the above statements: _____

Have you ever received Acupuncture before? Yes / No

What health concern(s) bring you in today? _____

_____

_____

Have you been examined by a medical doctor for any of these health concerns? Yes / No

If yes, what was your medical diagnosis: _____

_____

List any medications/supplements you are currently taking: _____

_____

List any known allergies: _____

List any significant traumas (accidents, falls, injuries): _____

_____

List any significant surgeries you have had:_____

_____

Do you have any type of bleeding disorder? Yes / No

Do you have a pacemaker? Yes / No

Have you ever been diagnosed with any of the following? Circle all that apply:

Diabetes	Blood Clots	Asthma
High Blood Pressure	Heart Attack	Tuberculosis
Low Blood Pressure	Stroke	HIV/AIDS
Anemia	Seizures	Hepatitis B

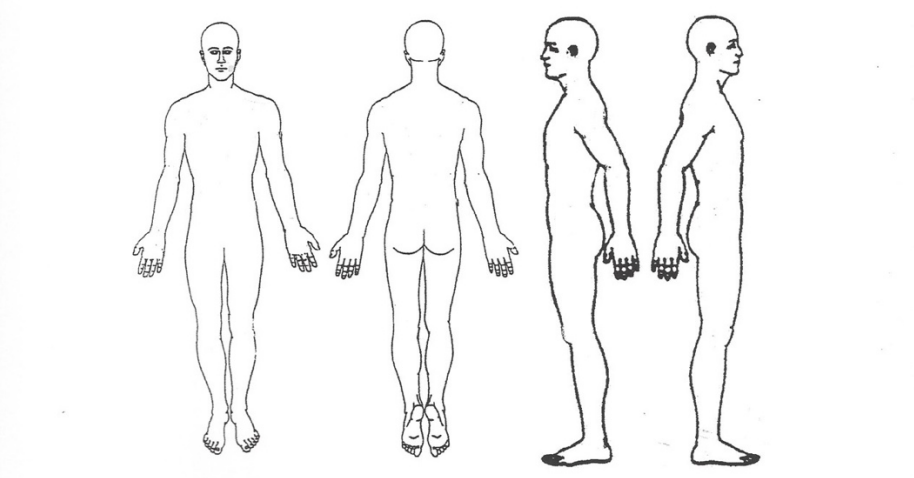
Family Medical History (parents, siblings, grandparents): _____

_____

_____

_____

If you have any aches or pains, mark the areas where you experience pain:



List what you typically eat during the day: Gluten free Vegetarian Vegan Other

Breakfast: _____

Lunch: _____

Afternoon snacking: _____

Dinner: _____

Evening snacking: _____

Foods you avoid/minimize: _____

How many ounces of water do you drink in a day? _____

How much caffeine do you consume daily? _____

How much alcohol do you consume in a week? _____

How many hours of sleep do you get per night? _____

Health History

Please mark any symptoms that you have or have had in the past year.

Temperature

- ☐ Tend to feel hot
- ☐ Tend to feel cold
- ☐ Hot flashes
- ☐ Chills
- ☐ Fever
- ☐ Alternating chills and fever
- ☐ Sweats during the day
- ☐ Night sweats

Head

- ☐ Headaches
- ☐ Migraines
- ☐ Dizzy/Vertigo
- ☐ Fainting
- ☐ Foggy-headedness
- ☐ Seizures/Tremors

Thirst

- ☐ Thirsty and drink cold
- ☐ Thirsty and drink hot
- ☐ Thirsty but don't drink
- ☐ Not thirsty

Eyes/Ears/Nose

- ☐ Declining vision
- ☐ Sensitivity to light
- ☐ Red/itchy eyes
- ☐ Floating spots
- ☐ Blurriness/Cloudiness
- ☐ Decreased hearing
- ☐ Ringing in the Ears
- ☐ Earaches
- ☐ Poor sense of smell
- ☐ Sinus congestion
- ☐ Nasal discharge

Skin, Hair & Nails

- ☐ Thin skin/nails
- ☐ Dry skin/nails
- ☐ Dry/brittle hair
- ☐ Easily bruised
- ☐ Acne
- ☐ Prematurely gray hair
- ☐ Hair loss

Lungs and Heart

- ☐ Wheezing
- ☐ Coughing
- ☐ Short of breath
- ☐ Tightness in chest
- ☐ Chest pain
- ☐ Frequent colds
- ☐ Palpitations/fluttering sensation

Appetite & Digestion

- ☐ Excessive appetite
- ☐ Poor appetite
- ☐ Heartburn/acid reflux
- ☐ Nausea/vomiting
- ☐ Gas/belching
- ☐ Bloating/distention
- ☐ Abdominal pain

Cravings

- ☐ Sweet
- ☐ Salty
- ☐ Sour
- ☐ Bitter
- ☐ Hot/Spicy
- ☐ Bland

Bowel Movements

- ☐ Constipation
- ☐ Loose stool/diarrhea
- ☐ Alternating constipation & diarrhea
- ☐ Burning with BM
- ☐ Blood or mucus in stool
- ☐ Foul odor

Urination

- ☐ Dark urine
- ☐ Cloudy urine
- ☐ Burning urination
- ☐ Scanty urine
- ☐ Profuse urine
- ☐ Decreased bladder control
- ☐ Frequent urination

Sleep/Energy

- ☐ Insomnia
- ☐ Excessive sleep
- ☐ Difficulty falling asleep
- ☐ Waking during the night
- ☐ Vivid dreams
- ☐ Wake unrefreshed
- ☐ High energy
- ☐ Good energy
- ☐ Low energy/fatigued

Mental & Emotional

- ☐ Forgetful/poor memory
- ☐ Poor concentration
- ☐ Irritable/angry
- ☐ Sad
- ☐ Anxious/worried
- ☐ Fearful/easily startled
- ☐ Depressed
- ☐ Frequent sighing/ yawning

Women's Health History

Menstruation

Age when menses began: _____

Menstruation lasts _____days

I have a:

- Regular cycle of _____days
- Irregular cycle of _____to _____days

During your period, do you experience any:

- Dysmenorrhea (Cramps)
- Fatigue
- Breast tenderness
- Sleep Disturbance
- Other: _____

During your period, the flow is:

- Light/spotting on days_____
- Medium on days _____
- Heavy on days _____

What color is the blood?

- Light Red on days _____
- Bright Red on days _____
- Dark Red on days _____
- Brown on days _____

Reproductive History

Are you currently using birth control? Y / N

Have you recently stopped or started birth control? Y / N

- If so, when? _____

Are you trying to conceive? Y / N

Have you given birth in the last year? Y / N

- Are you currently lactating? Y / N

Have you had any:

- High-risk pregnancies
- Difficult labor/deliveries
- Postpartum depression/concerns

Menopause

Are you perimenopausal? Y / N

- Do you currently experience any:
  - Night sweats/Cold flashes
  - Hot flashes (daytime)
  - Sleep Disturbance
  - Spotting
  - Other: _____

Are you postmenopausal? Y / N

- What year was your last period? _____

Thank you for choosing Finish Line Community Acupuncture!

FINISH LINE WELLNESS FLW exceed & excel