Outer Cape Community Acupuncture

Health History and Registration

PATIENT INFORMATION

Date_____
Name_____
Nickname_____
Address_____
City State_____
Zip_____
Age_____ Birth date_____
Occupation _____
Primary Physician _____
How did you hear about OCCA?
_____

CONTACT INFORMATION

Home phone _____
Work phone _____
Other/cell phone _____
E-mail _____
Another person we may contact if needed:
Name _____
Relationship_____
Home phone_____
Work phone_____

HEALTH HISTORY

What are your primary concerns for coming in for treatment?
1_____
2_____
3_____
How is your sleep?
_____
How is your digestion?
_____
List medications or food supplements you are taking.
_____
_____
List serious illnesses, accidents or surgeries.
_____
_____

Circle illnesses that have occurred in blood relatives:

Diabetes High Blood Pressure
Stroke Cancer Heart Disease
Kidney Disease

Circle symptoms you have or have had in the last year:
Depression
Difficulty in focusing
Dizziness
Easily startled
Excessive worry
Excessive anger
Excessive fear
Fatigue/tiredness
Headaches
Loss of sleep/poor sleep
Loss or gain of weight
Nervousness/irritability
Overwhelmed by life

Circle conditions you have or have had in the past:

AIDS	Bleeding disorders
Allergies	Breast lump
Anemia	Cancer
Arthritis	Diabetes

How long has it been since you have had a complete medical exam?
_____

HEALTH HISTORY...CONTINUED

Circle symptoms you have or have had in the last year:

MUSCLE/JOINT/BONES

Tremors or Cramps Swollen joints

Pain, weakness, numbness in:

- Arms or Hips
- Back Legs
- Feet
- Neck
- Hands
- Shoulders
- Other_____

EYES/EAR/NOSE/THROAT/BREATHING

- Asthma/wheezing
- Blurred or failing vision
- Difficulty breathing
- Earache
- Enlarged glands
- Eye pain
- Frequent colds
- Hay fever
- Hoarseness
- Gum trouble
- Nose bleeds
- Loss of hearing
- Persistent cough
- Ringing in ears
- Sinus problems

SKIN

- Boils
- Bruise easily
- Dry skin
- Itching/rash
- Sensitive skin
- Sore won't heal
- Sweats

GENITO/URINARY

- Blood/pus in urine
- Frequent urination
- Inability to control urine
- Kidney infection/stones
- Lowered libido

CARDIOVASCULAR

- Chest pain
- Hardening of arteries
- High or low blood pressure
- Pain over heart
- Poor circulation
- Previous heart attack
- Rapid/irregular heart beat
- Swelling of ankles

GASTROINTESTINAL

- Belching, gas or bloating
- Colon trouble
- Constipation
- Diarrhea
- Difficulty swallowing
- Distention of abdomen
- Excessive hunger
- Gall bladder trouble
- Hemorrhoids (piles)
- Indigestion
- Nausea
- Pain over stomach
- Poor appetite
- Vomiting

FOR MEN ONLY

- Erection difficulties
- Penis discharge
- Prostate trouble

FOR WOMEN ONLY

- Bleeding between periods
- Clots in menses
- Excessive menstrual flow
- Extreme menstrual pain
- Irregular cycle
- Menopausal symptoms
- PMS
- Previous miscarriage
- Scanty menstrual flow

Could you be pregnant? _____

SIGNATURE

The information on this form is correct to the best of my knowledge.

Signature_____

Date _____