Fire and Water
Holistic Health

# Health History Intake

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Date:_____ Name: _____ DOB: _____

Address:_____

_____

Email:_____ Cell Phone:_____

Occupation:_____

Marital Status: S/M/D/W/Cohabitating Referred by:_____

Gender: M/F/_____ Sex: M/F/_____ Pronoun: She/Him/Their/_____

Emergency Contact:_____ Phone:_____

Reason for seeking acupuncture:_____

_____

_____

Other Diagnoses/Conditions:

_____

_____

_____

Do you have any of the following (circle):

Surgical Implants / Heart Monitor/ Diabetes/High Blood Pressure/ History of Fainting/Seizures/ Cancer/ AIDS/ HIV/ Hepatitis/ Pregnancy

Do you have any allergies/sensitivities to any medicines, food, or any other substances?

_____

_____

_____

Please list all the medications, vitamins, and nutritional supplements that you have taken in the past 3 months:_____

_____

_____

Are you now on a restricted diet? Please describe.

_____

_____

Please list any hospitalizations or surgeries within the last 5 years:

_____

_____

_____

Other Symptoms:

Sleep:
☐ Trouble Falling Asleep ☐ Waking Frequently or Sleeping Lightly ☐ Night Sweats
☐ Vivid Dreaming/Nightmares ☐ Sleeping Excessively (10+ hours)

Digestion:
☐ Acid Reflux ☐ Loose or Frequent Bowel Movements ☐Bowel Movements Less Than Once / Day or Difficult To Pass ☐ Fullness or Bloating ☐ Abdominal Pain ☐ Swings in Appetite ☐ Incontinence ☐ Frequently Thirsty

Urination:
☐ Frequent or Urgent ☐ Cloudy ☐ Hot or Burning ☐ Incontinence ☐ Dark or Scanty

Cardiovascular:
☐ Shortness of Breath ☐ Palpitations ☐ Chest Oppression/Heaviness ☐ Asthma
☐ Chronic Cough

Mood:
☐ Anxiety or Panic Attacks ☐ Depression ☐ Bipolar Disorder ☐ Personality Disorder
☐ Suicidal or Violent Thoughts

Misc:
☐ Sweating Easily ☐ Migraines ☐ Recurrent Headaches ☐ Seasonal Allergies
☐ Frequent Infections/Sickness

*I certify that the above medical information is correct to my knowledge.*

Signature: _____ Date: _____