Shaul Hendel, L.Ac.

Health History

Please fill out all information as completely as possible and bring completed form to your first appointment.

Name: ____ Date: __________
First Middle Last

Address:____

Phone: (Home)______________________ (Work)_________________________
(Cell)_______________________

Email: _____________________________ Birthdate:_______________________

Occupation:____

Person to Contact in Case of Emergency: (Name)___________________________
(phone) home:________________ Work:______________ Cell:____________

Primary Care Physician:____

List any known allergies:_______________________________________

List any significant major traumas/accidents or any surgery that you have had and approximate date:____
____
____
____

List any significant illnesses that you have had or currently have (Autoimmune disease, HIV/AIDS, Cancer, Diabetes, Heart Disease, Hepatitis, Seizures, Other)
____
____
____

List in order of priority your main reason (s) or health complaint (s) for which you are now seeking acupuncture treatment:
1.______________________________________Date of Onset:______________
2.______________________________________Date of Onset:______________
3.______________________________________Date of Onset:______________

List any prescription medications that you are currently taking:

Medication Name	Dosage	Month & Year Started

List any supplements or over the counter medications that you are currently taking:

Supplement or Medication Name	Dosage	Month & Year Started

Nutrition: Briefly describe average diet habits
How many regular meals per day: ______ Cups of coffee per week:_____
Dietary approaches followed (vegetarian or other):_______________________
____

Exercise: Briefly describe your weekly activity levels
____
____
____

If you smoke, indicate how many cigarettes a day:___________________

Sleep Habits – how many hours of sleep do you average per night?___________

Stress levels on average (check one): ___ high ___ medium ___ low

Please indicate if you have experienced any of the following conditions or symptoms by checking **P** for experienced in **PAST** and **C** for **CURRENTLY EXPERIENCING**.

P	C	General
		Chills
		Low energy
		Dizziness
		Excess Thirst
		Insomnia
		Sweat spontaneously
		Night sweating
		Lack of sweating
		Weight loss
		Weight gain
		Aversion to heat
		Aversion to cold

P	C	Eyes, Ear, Nose
		Headaches
		Spots in front of eyes
		Eye pain or strain
		Cataract
		Eye dryness
		Poor hearing
		Ear ringing
		Nosebleeds
		Sinus congestion
		Hayfever
		TMJ
		Mouth sores

P	C	Respiratory
		Asthma/Wheezing
		Persistent cough
		Coughing blood
		Shortness of breath
		Recurrent bronchitis

P	C	Skin/Hair
		Rashes
		Itching
		Dryness
		Hives
		Acne
		Hair Loss

P	C	Cardiovascular
		High cholesterol
		Pacemaker
		High blood pressure
		Low blood pressure
		Irregular heart beat
		Palpitations
		Chest pain
		Poor circulation
		Blood clots

Practitioner Notes:

Please indicate if you have experienced any of the following conditions or symptoms by checking **P** for experienced in **PAST** and **C** for **CURRENTLY EXPERIENCING**.

P	C	Gastrointestinal
		Nausea/Vomiting
		Heart burn/reflux
		Indigestion
		Bloating
		Gas
		Diarrhea/loose stools
		Constipation
		Blood in stool
		Abdominal pain
		Poor appetite
		Hemorrhoids

P	C	Genito-Urinary
		Frequent urination
		Incontinence
		Burning urination
		Impotence
		Low sexual energy

P	C	Musculoskeletal
		Arthritis
		Neck pain
		Back pain
		Joint Pain___________
		Muscle pain
		Muscle weakness
		Numbness

P	C	Emotional
		Easily Stressed
		Often irritable/angry
		Depression
		Anxiety

P	C	Women Only
		Abnormal pap smear
		Irregular periods
		<25 day cycle
		>35 day cycle
		Heavy periods
		Endometriosis
		Painful periods
		Premenstrual symptoms
		Breast lump (s)
		Genital sores
		Vaginal discharge
		Menopausal

Are you pregnant? ____yes ____no

Practitioner Notes: