Please Note: This is a confidential record of your medical history and will be kept in this office. Information contained here will not be released to any person except when you have authorized us to do so. If you have a preferred method of our contacting you please circle the e-mail address or phone number of your preferred choice; we will always try that method first.

Name _____
Address _____
City _____ State _____ Zip _____
e-mail address _____
Phones:
Home _____ Cell _____
Work _____ Extension _____

Gender (circle one) Male/Female/Transgender
If transgender:
preferred pronoun _____ gender at birth _____ gender on insurance _____

Age _____ Date of Birth _____
Employer _____ Occupation _____

Marital Status (circle one) Single/Married/Divorced/Separated/Widowed
Name of Spouse _____

Emergency Contact
Name _____ Relationship _____
Home Phone _____ Cell/Work Phone _____

How did you find out about us?

- Referred by (circle one) Friend/Relative/Professional
  Name _____
- Other _____

Primary Care Physician:
Name _____ Telephone _____
Address _____ City _____ State _____ Zip _____

_____ _____
Signature of Patient (or Responsible Party if Patient is a Minor) Date

_____ _____
Printed Name of Signer Relationship to Patient

Barrington Acupuncture Clinic **Health History**

Patient Name Date

Reason for visiting Barrington Acupuncture Clinic _____

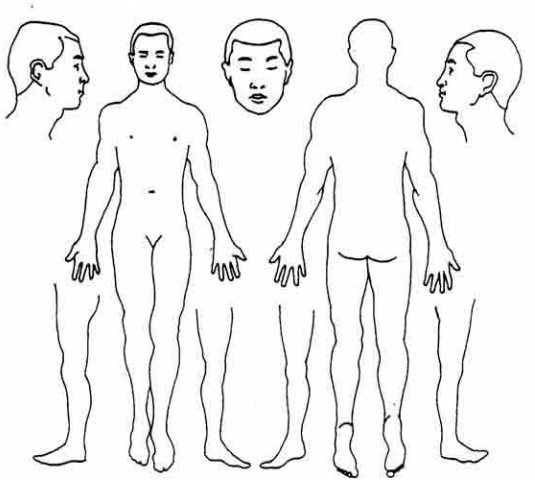
_____

_____

Are you experiencing pain/discomfort in any area of your body (circle one)? Yes/No

If yes, using the models below to indicate the location of discomfort by using the symbol that best describes the feeling:

XXX Sharp/stabbing
PPP Pins & Needles
DDD Dull/Aching
NNN Numbness



Medical History:
Do you have any of the following (please circle)?
Diabetes, High Blood Pressure, High Cholesterol, Thyroid Disease, Cancer, HIV, Hepatitis, Seizures

If yes, please indicate when diagnosed for each condition selected _____

_____

_____

_____

_____

Surgical History:

_____ Date
_____ Date
_____ Date
_____ Date
_____ Date

For Women: Are you pregnant now? Yes/No (circle one)

Patient Name Date

Medications/Supplements

To the best of your memory please include prescription medications, supplements, herbal supplements and over the counter (OTC) medicines you take on a regular basis

Allergies (medications, chemicals, foods, animals, insects, plants or environmental):

Family History:

Please check all that apply and state how you are related to the family member with that condition.

Condition	Mother	Father	Sibling	Maternal Grandparent	Paternal Grandparent
Heart disease					
Cancer					
Hypertension					
Stroke					
Asthma					
Allergies					
Migraines					
Depression					
Other mental illness					
Osteoporosis					
Diabetes					
Glaucoma					

Please comment on anything else that you think is relevant.

Barrington Acupuncture Clinic **Health History**

Patient Name _____ Date _____

Please check all that apply:

General
- ____ Appetite - Poor/Excessive
- ____ Change in appetite
- ____ Excessive thirst
- ____ Insomnia
- ____ Fatigue
- ____ Fever/Chills
- ____ Catch cold easily
- ____ Excessive sweating
- ____ Night Sweats
- ____ Localized weakness
- ____ Poor coordination
- ____ Bleed or bruise easily
- ____ Thyroid - low/high
- ____ Other_____

Musculoskeletal
- ____ Stiff neck/shoulders
- ____ Low back pain
- ____ Muscle spasm/twitching/cramps
- ____ Sore/cold/weak knees
- ____ Joint pain
- ____ Replacement joint/prosthesis

Skin & Hair
- ____ Rashes/Hives
- ____ Itching
- ____ Eczema/Psoriasis
- ____ Pimples/Acne
- ____ Dryness
- ____ Lumps/tumors

Head & Neck
- ____ Dizziness/Fainting
- ____ Headaches
- ____ Concussions
- ____ Stiff neck

Eyes Blurred vision
- ____ Visual changes
- ____ Poor night vision
- ____ Floaters
- ____ Cataracts
- ____ Eye inflammation
- ____ Glasses/Contacts
- ____ Near/far sighted
- ____ Other_____

Ears Hearing loss
- ____ Ringing
- ____ Infection
- ____ Hearing aid
- ____ Other_____

Nose, Throat, Mouth
- ____ Nose bleeds
- ____ Sinus infections
- ____ Hay fever/allergies
- ____ Recurring sore throats
- ____ Grinding teeth
- ____ Difficulty swallowing
- ____ Other_____

Respiration
- ____ Asthma
- ____ Bronchitis
- ____ Frequent Colds
- ____ Chronic Obstructive Pulmonary Disease
- ____ Pneumonia
- ____ Chronic cough
- ____ Coughing blood
- ____ Phlegm production
- ____ Other_____

Cardiovascular
- ____ Low/high blood pressure
- ____ Palpitations
- ____ Blood clots
- ____ Chest pain
- ____ Irregular heart beat
- ____ Cold hands/feet.
- ____ Fainting
- ____ Difficulty breathing
- ____ Swelling of hands/feet
- ____ Other_____

Gastrointestinal
- ____ Nausea
- ____ Vomiting
- ____ Diarrhea
- ____ Constipation
- ____ Belching
- ____ Bad breath
- ____ Pain/cramps
- ____ Indigestion
- ____ Gas
- ____ Hemorrhoids
- ____ Gall bladder disorder
- ____ Blood in stool/black stool
- ____ Other_____

Urinary
- ____ Frequent urination
- ____ Urgency to urinate
- ____ Painful urination
- ____ Unable to hold urine
- ____ Blood in urine
- ____ Kidney stones
- ____ Other_____

Infectious
- ____ HIV
- ____ TB
- ____ Hepatitis
- ____ Gonorrhea
- ____ Chlamydia
- ____ Syphilis
- ____ Genital warts
- ____ Herpes - oral
- ____ Herpes - genital

Neurological
- ____ Numbness/tingling of limbs
- ____ Pain
- ____ Seizures
- ____ Tremors
- ____ Concussion
- ____ Paralysis
- ____ Other_____

Psychological
- ____ Anxiety/stress
- ____ Depression
- ____ Irritability
- ____ Other_____

Female
- ____ Frequent urinary tract infections
- ____ Frequent vaginal infections
- ____ Pain/itching of genitals
- ____ Abnormal pap smear
- ____ Irregular menstrual periods
- ____ Painful menstrual periods
- ____ PMS
- ____ Abnormal bleeding
- ____ Menopausal
- ____ Hot Flashes
- ____ Breast tenderness/lumps
- ____ Other_____

Male
- ____ Pain/itching of genitals
- ____ Weak urinary system
- ____ Lumps in testicles
- ____ Other_____