

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 _____ Mobile _____

Gender (circle one) Male/Female/Transgender/Non-Binary

If transgender or non-binary:

preferred pronoun _____ gender at birth _____ gender on insurance _____

Age _____ Date of Birth _____
 Employer _____ Occupation _____

Relationship Status (circle one)

Single, Married, Divorced, Separated, Widowed, Domestic Partner

Name of Spouse/Partner _____

Emergency Contact

Name _____ Relationship _____

Home or Mobile Phone (circle one) _____

How did you find out about us?

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

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

 Date

 Printed Name of Signer

 Relationship to Patient

215 S Northwest Hwy Suite 102B
 Barrington IL 60010
 Phone 847-382-1884

We are located on the east side of Northwest Highway (Route 14)
 south of Main St (Lake Cook Rd)

Patient Name _____

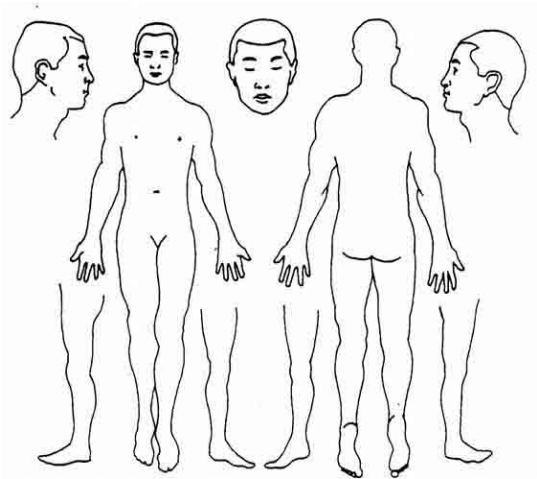
Date _____

Reason for visit _____

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



Surgical History:

_____	Date
_____	Date
_____	Date
_____	Date
_____	Date

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

Medications/Supplements

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):

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
- COPD
- 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
- Genital warts
- Herpes - oral
- Herpes - genital
- Other _____

Neurological

- Numbness/tingling
- 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 _____