

Harley Duff Bogley, A.P., Dipl. Ac. (NCCAOM) • Joyful Heart Acupuncture
Patient History

Patient Information

Date: _____
Name _____
Address _____
City State Zip _____
Home Phone _____
Work Phone _____
Cell Phone _____
Email, if used regularly _____
Age _____ Birthdate _____
Birth Place _____
Education _____
Occupation _____
Employer _____
Who may I thank for referring you? _____
Emergency contact, if needed. List Name, Relationship, Phone Numbers

Primary Physician _____ Phone # _____
Date of last visit _____
Last dental visit _____
How often do you see your dentist? _____

What concerns would you like to address in your acupuncture treatments?
How long have you had the condition(s)?

Your health history as a child - list year/condition

Your health history as an adult - list year/condition

Hospitalizations, surgeries, accidents:

Family Health History (blood relatives - are your parents living, health condition, siblings, etc.):

Medications: List all medications/food supplements you currently take.

Lifestyle

Typical breakfast _____

Typical lunch _____

Typical dinner _____

Snacks & times eaten _____

What foods do you crave? _____

What type of exercise do you do and how often? _____

Check which substances you use and how often

- Tobacco _____
- Alcohol _____
- Caffeine _____
- Drugs _____

Preferences

Best time of day _____

Most challenging _____

Best season of year _____

Most challenging _____

What is your favorite color? _____

Least favorite _____

Rank your preferences for tastes:

1= Least Favorite 5=Most Favorite

Salty _____ Sweet _____ Bitter _____

Spicy _____ Sour _____

Please review carefully and check the box if it applies:

- Have you gained or lost more than 10 pounds in the last 6 months?
- Do you have a tendency to be too hot or too cold?
- Have you lost your interest in eating lately?
- Do you always seem to be hungry?
- Are you more thirsty than usual lately?
- Are there any swellings in your armpits or groin?
- Do you get motion sickness riding in cars or planes?

Please review carefully and check the box if it applies:

- Do you have any skin problems?
- Does your skin itch or burn?
- Do you have trouble stopping even a small cut from bleeding?
- Do you bruise easily?
- Do you have eczema or dermatitis that recurs/lasts more than a month?
- Are you troubled by heartburn?
- Do you feel bloated after eating?
- Are you troubled by excessive belching?
- Do you suffer discomfort in the pit of your stomach?
- Are you troubled by excessive gas?
- Do you have trouble digesting fats?
- Do you often eat to calm down?
- Do you ever faint or feel faint?
- Is any part of your body always numb?
- Have you ever had seizures or convulsions?
- Has your handwriting changed lately?
- Do you have a tendency to shake or tremble?
- Do you have headaches more than once a week?
- Do you wear glasses?
- Does your eyesight ever blur?
- Is your eyesight getting worse?
- Have you had any trouble with your eyes in the last two years?
- Are you very nervous around strangers?
- Do you find it hard to make decisions?
- Do you find it hard to concentrate or remember?
- Do you usually feel lonely or depressed?
- Do you often cry?
- Would you say you have a hopeless outlook?
- Do you have difficulty relaxing?
- Do you have a tendency to worry a lot?
- Are you troubled by frightening dreams or thoughts?
- Do you have a tendency to be shy or sensitive?
- Do you have a strong dislike for criticism?
- Do you lose your temper often?
- Do little things often annoy you?
- Are you disturbed by any work or family problems?
- Are you having any sexual difficulties?
- Have you ever desired or sought psychiatric help?
- Have you ever been told that you had high blood pressure?
- Have you ever been told that you had low blood pressure?
- Do you have trouble with dizziness or lightheadedness?
- Do you have trouble with swollen feet or ankles?
- Have you ever been told that you have a heart murmur?
- Are you constipated more than two times monthly?
- Are your bowel movements ever loose for more than a day or two?
- Are your bowel movements ever black in color or bloody?
- Do you experience pain during bowel movements?
- Have you had any bleeding from your rectum?
- Do you have frequent colds?
- Is your nose stuffed up when you don't have a cold?
- Does your nose run when you don't have a cold?
- Have you ever had cold sores/fever blisters?

- Do you ever have sneezing spells?
- Does your nose ever bleed for no reason?
- Do you wheeze or have to gasp for breath?
- Do you yawn frequently?
- Are you bothered by coughing spells?
- Do you get chest colds more than once a month?
- Do you cough up a lot of phlegm ?
- Do you cough up blood?
- Do you have difficulty hearing?
- Have you had any earaches lately?
- Have you been troubled by ringing in your ears?
- Do you have trouble with your teeth?
- Have your taste senses changed lately?
- Do you have frequent urinary tract infections?
- Do you frequently get up at night to urinate?
- Do you urinate more than five to six times a day?
- Do you wet your pants or wet your bed?
- Have you ever had burning or pain when you urinate?
- Do you have frequent water retention?
- Do you seem to feel exhausted or fatigued most of the time?
- Do you have difficulty either falling asleep or staying asleep?
- Do you use sleeping pills regularly?
- Are you sweating more than usual or having night sweats?
- Do you have cold hands and feet?
- Do you have warm and/or sweaty hands and feet?

Women ONLY

- Was your last menstrual period normal? Date _____
- Are you past your menstrual cycles and in menopause?
- Have you had bleeding between your periods?
- Do you have heavy bleeding with your periods?
- Do you have excessive cramping with your periods?
- Do you have clots in your menses?
- Are you sexually active?
- Do you use contraception and/or condoms?
- Do you now or have you ever had a sexually transmitted disease?
- Are you sexually fulfilled and satisfied?
- Number of pregnancies _____
- Number of children born alive _____
- Number of premature births _____
- Number of miscarriages _____
- Number of stillbirths _____
- Number of abortions _____

Men ONLY

- Is your urine stream weak and slow?
- Has a doctor ever told you that you have prostate trouble?
- Have you had any burning or discharge from your penis?
- Are there any swellings or lumps on your testicles?
- Are you sexually active?
- Do you now or have you ever had a sexually transmitted disease?
- Do you use contraception and/or condoms?
- Are you sexually fulfilled and satisfied?