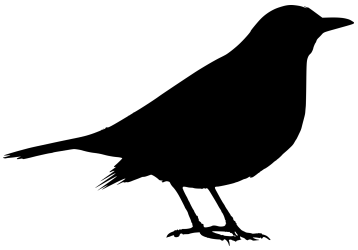

BLACKBIRD
ACUPUNCTURE CLINIC LLC

COMPREHENSIVE HEALTH HISTORY

Name | Today's Date

Address | City | State | Zip

Phone | Do you receive texts? Yes/No

Email | Marital/Relationship Status

Date of Birth | Age | Gender | Height | Weight

Emergency Contact | Phone

Primary Physician | Phone/Clinic

Occupation | Employer

How did you hear about Blackbird Acupuncture Clinic?

Please list your major health concerns in order of importance.
If you could have only one concern improved after leaving here today, which concern would it be? Indicate that concern with a star.

Complaint	Since (time/day/mo/yr)	Severity (1-10, 10=severe)	Other Treatment (MD, DC, DO, etc.)

HEALTH HISTORY CONTINUATION

How does each complaint above interfere with your daily living (i.e. sleep, activities)?

_____

_____

What makes each complaint above better (i.e. heat, cold, rest):

_____

_____

What makes each complaint above worse (i.e. heat, cold, rest):

_____

_____

Have you ever been diagnosed with any of the following:

- ☐ Diabetes
- ☐ Arthritis
- ☐ Depression
- ☐ Anxiety
- ☐ MRSA
- ☐ High blood pressure
- ☐ Heart attack
- ☐ HIV/AIDS
- ☐ Hepatitis
- ☐ C-Dif
- ☐ Anemia
- ☐ Hyper/hypo Thyroid
- ☐ Stroke
- ☐ Asthma
- ☐ Cancer
- ☐ Ulcer/GI Bleeding
- ☐ Autoimmune disorder (Fibromyalgia, MS, Lyme)
- ☐ Bleeding disorder
- ☐ Chronic headache
- ☐ Migraines

Please list any prescriptions or over-the-counter medications or supplements you are currently taking:

Medication/Supplement	Reason	Dosage	How Long?

Please list all hospitalizations, surgeries, and traumas:

When	Reason

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HEALTH HISTORY CONTINUATION

Please list all known drug or food (shellfish, nut, diary, gluten, etc.) allergies/intolerances:

_____

_____

_____

Family medical history (parents, siblings, grandparents):

_____

_____

What are your short-term wellness goals?

_____

_____

What are your long-term wellness goals?

_____

_____

Please mark any symptoms you currently have or have had in the past year:

HEAD/EARS/EYES/MOUTH

- ☐ Poor sense of smell
- ☐ Ear ringing
- ☐ Frequent Sore Throats
- ☐ Sinus congestion
- ☐ Ear Aches
- ☐ Mouth/Canker Sores
- ☐ Infection
- ☐ Dizziness/Vertigo
- ☐ Lip Sores
- ☐ Nasal discharge
- ☐ Fainting/Lightheaded
- ☐ Dry, chapped lips
- ☐ Nosebleeds
- ☐ Seizures
- ☐ Dry mouth, throat
- ☐ Dry, red, or itchy eyes
- ☐ Tremors
- ☐ Difficulty swallowing
- ☐ Blurred vision
- ☐ Headaches/Migraines
- ☐ Painful/bleeding Gums
- ☐ Decreased night vision
- ☐ Grinding Teeth
- ☐ Sensitive to light
- ☐ Poor Teeth
- ☐ Floating spots in vision
- ☐ Weak, hoarse voice
- ☐ Cataracts
- ☐ Poor or decreased hearing

TEMP/SWEATING

- ☐ Tend to feel hot
- ☐ Sweat with little exertion
- ☐ Tend to feel cold
- ☐ Night sweats
- ☐ Hot flashes
- ☐ Can't sweat
- ☐ Chills
- ☐ Fever
- ☐ Alternating chills & fever

CHEST & ABDOMEN

- ☐ Wheezing
- ☐ Coughing
- ☐ Shortness of breath
- ☐ Tight sensation in chest
- ☐ Frequent colds,
- ☐ Seasonal allergies
- ☐ Palpitations
- ☐ Chest pain
- ☐ Stomach pain/pressure
- ☐ Bloating
- ☐ Abdomen pain/pressure
- ☐ Ribside pain

SKIN, HAIR, & NAILS

- ☐ Dry skin, nails Oily skin
- ☐ Dry hair
- ☐ Oily hair Acne
- ☐ Rashes, hives, itching
- ☐ Sores that won't heal
- ☐ Easily bruised
- ☐ Prematurely grey hair
- ☐ Hair loss

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HEALTH HISTORY CONTINUATION

Please mark any symptoms you currently have or have had in the past year:

APPETITE/DIGESTION

- ☐ Excessive appetite
- ☐ Poor appetite
- ☐ Bad breath
- ☐ Heartburn/reflux
- ☐ Belching/hiccups
- ☐ Nausea/vomiting
- ☐ Thirsty & drink cold
- ☐ Thirsty & drink hot
- ☐ Thirsty but don't drink
- ☐ Not thirsty
- ☐ Gas
- ☐ Gall stones
- ☐ Food sensitivities
- ☐ Crave salt
- ☐ Crave sugar
- ☐ Weight gain _____ lbs
- ☐ Weight loss _____ lbs
- ☐ Consume caffeine
- ☐ Smoke cigarettes
- ☐ Chew tobacco
- ☐ Drink alcohol
- ☐ Use drugs
- ☐ Little activity/exercise
- ☐ Exercise excessively
- ☐ Eating disorder

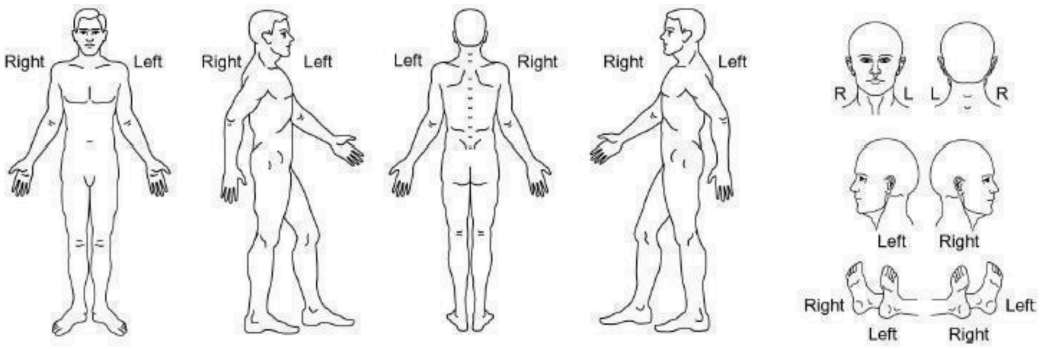
URINATION & BOWEL MOVEMENTS

- ☐ Dark urine
- ☐ Pale urine
- ☐ Cloudy urine
- ☐ Scanty urine
- ☐ Profuse urine
- ☐ Blood in urine
- ☐ Burning urination
- ☐ Painful urination
- ☐ Frequent urination
- ☐ Frequent UTIs
- ☐ Kidney stones
- ☐ Urinary urgency
- ☐ Incontinence
- ☐ Dribbling urine
- ☐ Weak urine stream
- ☐ Difficulty emptying bladder
- ☐ Constipation
- ☐ Loose stool/diarrhea
- ☐ Alternating diarrhea, constipation
- ☐ Cramps with BM
- ☐ Incomplete BM
- ☐ Burning with BM
- ☐ Blood, mucus in stool
- ☐ Foul odor
- ☐ Sticky stool

MUSCULOSKELETAL & EXTREMITIES

- ☐ TMJ
- ☐ Muscle spasm
- ☐ All over body pain
- ☐ Muscle tightness
- ☐ Joint swelling
- ☐ Joint pain
- ☐ Weak back
- ☐ Weak knees
- ☐ Body heaviness
- ☐ Cold back or knees
- ☐ Tremors
- ☐ Numbness/tingling

INDICATE AREAS WHERE YOU FEEL PAIN, NUMBNESS OR TINGLING:



SLEEP

- ☐ Insomnia
- ☐ Excessive sleep
- ☐ Difficulty falling asleep
- ☐ Difficulty staying asleep
- ☐ Vivid dreams
- ☐ Scary dreams
- ☐ Wake unrefreshed

ENERGY

- ☐ High energy
- ☐ Nervous Energy
- ☐ Good energy
- ☐ OK energy/slightly low
- ☐ Low energy/fatigue
- ☐ Energy drops (time of day)
  _____ am / pm
  _____ am / pm

MENTAL/EMOTIONAL

- ☐ Forgetful/poor memory
- ☐ Trouble focusing
- ☐ Irritable/angry
- ☐ Sad/weepy
- ☐ Anxious/worry
- ☐ Mind racing
- ☐ Fearful, easily frightened
- ☐ Easily stressed
  Reason(s) for stress:_____

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HEALTH HISTORY CONTINUATION

Please mark any symptoms you currently have or have had in the past year:

SEXUAL HEALTH

- ☐ High sexual energy
- ☐ Low sexual energy
- ☐ Genital pain/itching
- ☐ Genital lesions
- ☐ Discharge
- ☐ Painful intercourse
- ☐ Infertility
- ☐ Chronic yeast infection
- ☐ Vaginal dryness
- ☐ Fibroids, cysts
- ☐ Breast lumps/nodules
- ☐ Endometriosis
- ☐ Abnormal pap smears
- ☐ PCOS
- ☐ STDs
- ☐ Erectile dysfunction
- ☐ Premature ejaculation
- ☐ Nocturnal emission
- ☐ Enlarged prostrate
- ☐ Painful, swollen testicles

MENOPAUSE

- ☐ Peri-menopausal
- ☐ Post-menopause since _____

PMS

- ☐ Acne
- ☐ Cramps before/during period
- ☐ Cramps after/during period
- ☐ Breast changes/tenderness
- ☐ Bowel changes
- ☐ Bloating
- ☐ Food cravings
- ☐ Irritability/anger
- ☐ Sad/weeping
- ☐ Headaches/Dizziness
- ☐ Indigestion/Nausea
- ☐ Other: _____

MENSTRUATION

Age of 1st menstruation: _____
Menstruation lasts _____ days
Regular cycle: _____ days total
Irregular cycle: _____ to _____ days

MENSTRUAL FLOW

During your period, the flow is:

Light/spotting on days _____
Medium on days: _____
Heavy on days: _____
With clots on days: _____
Spotting btwn cycles: Yes ___ No ___

MENSTRUAL BLOOD

Indicate only applicable answers:

Light red on days: _____
Bright red on days: _____
Dark red on days: _____
Purple on days: _____
Brown on days: _____
Black on days: _____

POST-MENSTRUATION

- ☐ Dizziness
- ☐ Fatigue
- ☐ Insomnia
- ☐ Night sweats
- ☐ Other: _____

REPRODUCTIVE HISTORY

Are you currently using birth control?
☐ Yes ☐ No

Type:_____

Currently pregnant?
☐ Yes ☐ No

How many pregnancies have you had? _____

How many children do you have? _____

Are you trying to conceive?
☐ Yes ☐ No

Are you currently lactating?
☐ Yes ☐ No

How many abortions have you had? _____

How many miscarriages have you had? _____