

OAK HILL HEALING ARTS

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www.oakhillacupuncture.com

PERSONAL INFORMATION

NAME _____

DATE _____

ADDRESS _____ CITY _____

STATE _____ ZIP _____

PHONE _____ DATE OF BIRTH _____

MARITAL STATUS _____ SEX _____ AGE _____ NUMBER OF

CHILDREN _____

OCCUPATION _____

ADDRESS _____ CITY/ZIP _____ HOME

PHONE _____

EMAIL _____ CELL PHONE

EMERGENCY NOTIFICATION

NAME _____

TELEPHONE _____

REFERRED

BY _____

CURRENT HEALTH CONDITION

PURPOSE OF THIS

APPOINTMENT _____

—
TODAYS CONDITION STARTED

WHEN? _____

WHAT ACTIVITIES AGGRAVATE YOUR

CONDITION? _____

WHAT ACTIVITIES LESSEN YOUR
CONDITION? _____

IS CONDITION WORSE DURING CERTAIN TIMES OF THE
DAY? _____

IS THIS CONDITION INTERFERING WITH WORK? _____ SLEEP? _____ ROUTINE?

OTHER DOCTORS SEEN FOR THIS
CONDITION _____
TYPE OF TREATMENT &
RESULTS _____

Other _____

MEDICATIONS: _____

SUPPLEMENTS: _____

LIFESTYLE/DIET/EXERCISE: _____

- | | | | |
|---|--|---|--|
| <input type="checkbox"/> RINGING IN EAR _____ | <input type="checkbox"/> GALL BLADDER TROUBLE _____ | <input type="checkbox"/> TREMOR/HANDS SHAKING _____ | MEASLES <input type="checkbox"/> RUBELLA <input type="checkbox"/> RHEUMATIC FEVER |
| <input type="checkbox"/> EAR INFECTIONS - <i>FREQUENT</i> _____ | <input type="checkbox"/> JAUNDICE/HEPATITIS _____ | <input type="checkbox"/> MUSCLE WEAKNESS _____ | <input type="checkbox"/> SCARLET FEVER <input type="checkbox"/> TUBERCULOSIS <input type="checkbox"/> HERPES |
| <input type="checkbox"/> DIZZINESS/FAINTING _____ | <input type="checkbox"/> CHANGE IN BOWEL HABITS _____ | <input type="checkbox"/> NUMBNESS/TINGLING SENSATIONS _____ | <input type="checkbox"/> OTHER _____ |
| <input type="checkbox"/> FAILING VISION _____ | <input type="checkbox"/> DIARRHEA <input type="checkbox"/> CONSTIPATION _____ | <input type="checkbox"/> HEADACHES - <i>FREQUENT</i> _____ | <input type="checkbox"/> OTHER _____ |
| <input type="checkbox"/> EYE INFECTIONS _____ | <input type="checkbox"/> DIVERTICULOSIS <input type="checkbox"/> CROHN'S/COLITIS _____ | <input type="checkbox"/> ARTHRITIS/RHEUMATISM _____ | Females - Please Complete |
| <input type="checkbox"/> NOSE BLEEDS _____ | <input type="checkbox"/> BLOODY OR TARRY STOOLS _____ | <input type="checkbox"/> OSTEOPOROSIS _____ | PREGNANT? <input type="checkbox"/> YES <input type="checkbox"/> NO |
| <input type="checkbox"/> SINUS TROUBLE _____ | <input type="checkbox"/> HEMORRHOIDS _____ | <input type="checkbox"/> BACK PAIN - <i>RECURRENT</i> _____ | PLANNING PREGNANCY? <input type="checkbox"/> YES <input type="checkbox"/> NO |
| <input type="checkbox"/> SORE THROATS - <i>FREQUENT</i> _____ | <input type="checkbox"/> HERNIA _____ | <input type="checkbox"/> BONE FRACTURE/JOINT INJURY _____ | Menstrual Flow: |
| <input type="checkbox"/> HAYFEVER/ALLERGIES _____ | <input type="checkbox"/> URINE INFECTIONS - <i>FREQUENT</i> _____ | <input type="checkbox"/> GOUT _____ | <input type="checkbox"/> Regular <input type="checkbox"/> Irregular <input type="checkbox"/> Pain/Cramps |
| <input type="checkbox"/> PNEUMONIA _____ | <input type="checkbox"/> BLOOD IN URINE _____ | <input type="checkbox"/> FOOT PAIN <input type="checkbox"/> COLD NUMB FEET _____ | ____ Days of Flow ____ Length of Cycle |
| <input type="checkbox"/> BRONCHITIS/CHRONIC COUGH _____ | URINATION- <input type="checkbox"/> OVERNIGHT > THAN TWICE | <input type="checkbox"/> RASHES <input type="checkbox"/> HIVES _____ | Date-1st day of last period _____ |
| <input type="checkbox"/> ASTHMA/WHEEZING _____ | <input type="checkbox"/> PAINFUL <input type="checkbox"/> LOSS OF CONTROL | <input type="checkbox"/> PSORIASIS <input type="checkbox"/> ECZEMA _____ | <input type="checkbox"/> Pain/Bleeding during or after sex |
| <input type="checkbox"/> CHEST PAIN _____ | <input type="checkbox"/> DECREASE IN FORCE/FLOW | <input type="checkbox"/> NERVOUSNESS <input type="checkbox"/> DEPRESSION _____ | Number of: |
| <input type="checkbox"/> HIGH BLOOD PRESSURE _____ | <input type="checkbox"/> KIDNEY STONES _____ | <input type="checkbox"/> MEMORY LOSS _____ | ____ Pregnancies ____ Abortions |
| <input type="checkbox"/> HEART MURMUR _____ | <input type="checkbox"/> VENEREAL DISEASE _____ | <input type="checkbox"/> MOODINESS - <i>EXCESSIVE</i> _____ | ____ Miscarriages ____ Live Births |
| <input type="checkbox"/> SWOLLEN ANKLES _____ | <input type="checkbox"/> URETHRAL DISCHARGE _____ | <input type="checkbox"/> PHOBIAS _____ | Birth Control Method _____ |
| <input type="checkbox"/> LEG PAIN - <i>WALKING</i> _____ | <input type="checkbox"/> CHRONIC FATIGUE _____ | <input type="checkbox"/> MENTAL ILLNESS _____ | B.C. Pill (Name) _____ |
| <input type="checkbox"/> VARICOSE VEINS/PHLEBITIS _____ | <input type="checkbox"/> WEIGHT LOSS - <i>RECENT</i> _____ | <input type="checkbox"/> LACTOSE INTOLERANCE _____ | <input type="checkbox"/> Flushing/Menopause |
| <input type="checkbox"/> LOSS OF APPETITE _____ | <input type="checkbox"/> ANEMIA <input type="checkbox"/> BRUISE EASILY _____ | <input type="checkbox"/> PROSTATE DISEASE _____ | Date of Last PAP Test _____ |
| <input type="checkbox"/> DIFFICULTY SWALLOWING _____ | <input type="checkbox"/> CANCER _____ | <input type="checkbox"/> SEXUAL/MENSTRUAL DYSFUNCTION _____ | <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal |
| <input type="checkbox"/> INDIGESTION OR HEARTBURN _____ | <input type="checkbox"/> DIABETES _____ | <input type="checkbox"/> FREQUENT INFECTIONS _____ | Date of Last Mammogram _____ |
| <input type="checkbox"/> PERSISTENT NAUSEA/VOMITING _____ | <input type="checkbox"/> THYROID DISEASE _____ | <input type="checkbox"/> DIPHTHERIA _____ | <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal |
| <input type="checkbox"/> PEPTIC ULCERS _____ | <input type="checkbox"/> CONVULSIONS/SEIZURES _____ | <input type="checkbox"/> TETANUS _____ | |
| <input type="checkbox"/> ABDOMINAL PAIN - <i>CHRONIC</i> _____ | <input type="checkbox"/> STROKE _____ | <input type="checkbox"/> CHICKEN POX <input type="checkbox"/> POLIO <input type="checkbox"/> MUMPS <input type="checkbox"/> | |

Medical History

HOSPITALIZATIONS:

Date	Reason	Date	Reason

FAMILY HISTORY

PLEASE LIST ANY DISEASE OR DISORDERS IN YOUR IMMEDIATE FAMILY:
