Aloha E Komo Mai
(Hello and Welcome)

Welcome to our office. We are committed to providing the best, most comprehensive care possible. Please assist us by providing the following information. All information is confidential and is released only with your consent. Please fill in the blanks.

(Please Print)

Name _____

Address: _____City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Email: _____

Birth Date: _____ Sex: M F Age: _____

Marital Status: Single ☐ Married ☐ Divorced ☐ Widowed ☐

Employment: Full Time ☐ Part Time ☐ Retired ☐ Unemployed ☐ Student ☐ Disabled ☐

Occupation(s): _____ Employer's Name: _____

Emergency Contact: _____ Relationship: _____ Phone#: _____

Physicians Name: _____ Phone: _____

☐ I hereby give permission to release information related to my care to my physician.

Referred to our office by: _____
Have you had an Acupuncture treatment before?: _____ When? _____
What health issues would you like to address?: _____

IF YOU WERE INVOLVED IN AN ACCIDENT PLEASE COMPLETE THE FOLLOWING

Did the injury occur at **WORK**?_____ Date of injury: _____

Has the injury been reported to your supervisor? Yes _____ No_____

Is the injury a result of an **AUTOMOBILE ACCIDENT**? Yes ____ No _____ Other?_____

I do hereby certify that the preceding questions have been answered truthfully and completely to the best of my knowledge and belief.

Patient/Guardian Signature: _____ **Date:** _____

For Official Use Only

Ohana Acupuncture and Herbs
Acupuncture Patient History Form

Name: _____ Date: ____ / ____ /____
(first) (middle) (last)
Address: _____

Phone Number: _____ Email: _____ Date of Birth: _____

Age: _____ Gender: M / F Marital Status: S M D W

Successful health care and preventative medicine are only possible when the practitioner has a complete understand of t patient physically, mentally, and emotionally. Please complete this questionnaire as thoroughly as possible. Print all information and indicate areas of confusion with a question mark. Thank you.

Please identify your current health concerns in order of importance below:

Condition	**Past Treatment**
a. _____	_____
b. _____	_____
c. _____	_____
d. _____	_____

How does this condition affect you? _____

Please list any foods, drugs or medications you are hypersensitive of allergic to and reaction type:
_____
_____
Please list any medication (prescribed and over-the-counter), vitamins and supplements you are currently taking:

_____
_____

Do you have any reason to believe you are pregnant? Y N If so how many weeks? _____

Do you have any infections diseases? Y N If yes, please identify: _____

Please indicate if you have any of the following:
☐ Cancer ☐ Diabetes ☐ High Blood Pressure ☐ Heart Disease
☐ Hepatitis ☐ Seizures ☐ Thyroid Disease ☐ Other

Family History: Please check those applicable:	Father	Mother	Sibling(s)	Grandparents
Health (G=Good, P=Poor)	_____	_____	_____	_____
Cancer	_____	_____	_____	_____
Diabetes	_____	_____	_____	_____
Heart Disease	_____	_____	_____	_____
High Blood Pressure	_____	_____	_____	_____
Stroke	_____	_____	_____	_____
Mental Illness	_____	_____	_____	_____
Asthma/Hay Fever/Hives	_____	_____	_____	_____
Kidney Disease	_____	_____	_____	_____

Height: _____ Weight: (Currently) _____ Past Maximum: _____
Blood Pressure: What is your most recent blood pressure reading? _____ / _____ Date: _____

Childhood Illness (please circle any you have had):

Scarlet Fever Rheumatic Fever Mumps Measles Chicken Pox Polio

Hospitalization and Surgeries:

Reason When

_____
_____
_____

Please describe the types of food you eat daily, including snacks. _____
_____
_____
_____
_____

Please circle any that you experience now and underline any you have experience in the past in each category.

I. Emotional

Mood Swings Depression Anxiety Insomnia Frequent or Uncontrollable Anger Phobias

II. Energy and Immunity

Fatigue Slow Wound Healing Chronic Infections Chronic Fatigue Syndrome

III. Head, Eye, Ear, Nose and Throat

Impaired Vision Eye Pain/Strain Glaucoma Glasses/Contacts Tearing/Dryness

Impaired Hearing Ear Ringing Earaches Headaches Sinus Problems

Nose Bleeds Frequent Sore Throat Teeth Grinding TMJ/Jaw Problems Allergies

IV. Respiratory

Pneumonia Frequent Common Cold Difficulty Breathing Emphysema

Persistent cough Pleurisy Asthma Tuberculosis

Shortness of Breath Bronchitis Other Respiratory Problems: _____

V. Cardiovascular

Heart Disease Chest Pain Swelling of Ankles High Blood Pressure

Palpitations/Fluttering Stroke Heart Murmurs Rheumatic Fever Varicose Veins

VI. Gastrointestinal

Ulcers Changes in Appetite Nausea/Vomiting Epigastric Pain Passing Gas

Heartburn Belching Gall Bladder Disease Liver Disease Hemorrhoids

Abdominal Pain Acid Reflux Bloating

VII. Genito-Urinary Tract

Kidney Disease Painful Urination Frequent UTI Frequent Urination Heavy Flow

Kidney Stones Impaired Urination Blood in Urine Frequent Urination at Night

VIII. Male Reproductive

Sexual Difficulties Prostate Problems Testicular Pain/Swelling Penile Discharge

IX. Female Reproductive/Breasts

Irregular Cycles Breast Lumps/Tenderness Nipples Discharge Heavy Flow

Vaginal Discharge Premenstrual Problems Clotting Bleeding Between Cycles

Menopausal Symptoms Difficulty Conceiving Painful Periods Breast Carcinoma

X. Menstrual/Birthing History

Age of First Menses: _____ Birth Control Type: _____ #of Abortion: _____

# of Days of Menses: _____ # of Pregnancies: _____ # of Live Births: _____

Length of Cycle: _____ # of Miscarriages: _____

XI. Musculoskeletal

Neck/Shoulder Muscle Spasms/Cramps Arm Pain Upper Back Pain Mid Back Pain

Low Back Pain Leg Pain Joint Pain (if so, where?): _____

Neurologic

Vertigo/Dizziness Paralysis Numbness/Tingling Loss of Balance Seizures/Epilepsy

XII. Endocrine

Hypothyroid Hypoglycemia Hyperthyroid Diabetes Mellitus Night Sweats Feeling Hot or Cold

Other

Anemia Cancer Rashes Eczema/Hives Cold Hands/Feet Arthritis

Is there anything else we should know? _____

_____

XIII. Lifestyle

Do you typically eat at least three meals per day? Y N If no, how many? _____

Exercise routine: _____

How many hour per night do you sleep? _____ Do you wake rested? Y N

Occupation: _____ Hours/Week: _____

Do you enjoy your work? Y N Why or Why not? _____

Nicotine/Alcohol/Caffeine/Drug Use? _____

Interests/Hobbies: _____