John Ditmars, M.S., LAc., Dipl.Ac. (NCCAOM)

Patient Health History

Patient Name: ______________________________ Date: ________ DOB: __________

Address: ______________________________ Phone: ____________ Email: _______________

Emergency Contact/Relationship to You: ______________________________ Phone: _______________

What is your primary complaint/condition?: ______________________________

Check the following conditions that apply to you now.

Musculo-Skeletal

- ☐ Headaches
- ☐ Joint stiffness/swelling
- ☐ Spasms/cramps
- ☐ Broken/fractured bones
- ☐ Back, hip pain
- ☐ Shoulder, neck, arm, hand pain
- ☐ Leg, foot pain
- ☐ Chest, ribs, abdominal pain
- ☐ Problems walking
- ☐ Jaw pain / TMJ
- ☐ Tendonitis
- ☐ Bursitis
- ☐ Arthritis
- ☐ Osteoporosis
- ☐ Scoliosis
- ☐ Bone or join disease
- ☐ Other: ____________________

Circulatory and Respiratory

- ☐ Dizziness
- ☐ Shortness of breath
- ☐ Fainting
- ☐ Cold feet or hands
- ☐ Cold sweats
- ☐ Swollen ankles
- ☐ Pressure sores
- ☐ Varicose veins
- ☐ Blood clots
- ☐ Stroke
- ☐ Heart condition
- ☐ Allergies
- ☐ Sinus problems
- ☐ Asthma
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Lymphedemia
- ☐ Other:____________________

Skin

- ☐ Rashes
- ☐ Allergies
- ☐ Athlete's Foot
- ☐ Acne
- ☐ Cosmetic surgery
- ☐ Other: ____________________

Digestive

- ☐ Nervous stomach
- ☐ Indigestion
- ☐ Constipation
- ☐ Intestinal gas/bloating
- ☐ Diarrhea
- ☐ Diverticulitis
- ☐ Irritable bowel syndrome
- ☐ Crohn's Disease
- ☐ Adaptive aids
- ☐ Heartburn/acid reflux
- ☐ Early morning loose bowels
- ☐ Other:____________________

Nervous System

- ☐ Numbness/tingling
- ☐ Twitching of face
- ☐ Fatigue
- ☐ Chronic pain
- ☐ Sleep disorders
- ☐ Ulcers
- ☐ Paralysis
- ☐ Herpes/shingles
- ☐ Cerebral Palsy
- ☐ Epilepsy
- ☐ Chronic Fatigue Syndrome
- ☐ Multiple Sclerosis
- ☐ Muscular Dystrophy
- ☐ Parkinson's Disease
- ☐ Spinal cord injury
- ☐ Other:____________________

Reproductive System

- ☐ Pregnancy:
  - ☐ Current
  - ☐ Previous
- ☐ PMS
- ☐ Menopause
- ☐ Pelvic Inflammatory Disease
- ☐ Endometriosis
- ☐ Hysterectomy
- ☐ Fertility concerns
- ☐ Urinary problems
- ☐ Prostate problems
- ☐ Other: ____________________

Other

- ☐ Fatigue
- ☐ Loss of appetite
- ☐ Forgetfulness
- ☐ Confusion
- ☐ Depression
- ☐ Difficulty concentrating
- ☐ Drug use __________________
- ☐ Alcohol use ________________
- ☐ Nicotine use _______________
- ☐ Caffeine use _______________
- ☐ Hearing impaired
- ☐ Visually impaired
- ☐ Burning upon urination
- ☐ Bladder infection
- ☐ Eating disorder
- ☐ Diabetes
- ☐ Fibromyalgia
- ☐ Post/Polio Syndrome
- ☐ Cancer
- ☐ Lyme Disease
- ☐ Painful scars
- ☐ Other:____________________
  ____

Surgeries or major medical interventions: ______________________________

____

Congenital or Acquired Ailments: ____
____
____

Pain or Discomfort:

If you experience pain, please describe the quality of the pain. Please circle appropriate choices:

Dull	Aching	Sharp	Electric
Radiating	Hot	Cold	Other

Please Describe: ____
____
____

What improves your pain?

Massage	Cold	Warmth
Movement	Staying Still	Other

Please Describe: ____
____
____

What makes your pain worse?

Massage	Cold	Warmth	Stress
Movement	Staying Still	Other	

Please Describe: ____
____
____

Stress:

When you feel stressed, what part(s) of your body do you feel it in? How do you feel your body responds to stress?

____
____
____

Medications, Supplements, and Herbs

Please list all medications, supplements/vitamins, herbs, and over the counter drugs that you take.

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____
____

Please list anything else you'd like to discuss about your reasons for seeking acupuncture treatment.

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________________________________ ________________________________ ____________

Patient Print Name **Patient Signature** **Date**