solstice health
acupuncture and herbal medicine

Medical History

Confidential

General Information

Patient Name____

Patient Address____

City______________________ State______________________ Zip______________________

Home Phone ______________________ Work Phone______________________

Gender______________ Age______________ DOB ___/___/___ Weight______________

Marital Status______________ Occupation______________________

Primary Practitioner (Medical Doctor)______________________ Date of last visit___/___/___

Reason for Visit____

Have you received acupuncture/Chinese Herbs in the past? ❑ Yes ❑ No

Name of Acupuncturist ______________________ Date of last visit___/___/___

Reason for Visit____

Emergency Contact

Name______________________ Relationship______________________

Address______________________ Phone______________________

Major Concern

What is your primary reason for this visit?____

____

____

This condition is due to ❑ Automobile Injury ❑ Work Injury ❑ Sports Injury ❑ Illness ❑ Not sure ❑ Other

If Other, please explain____

What was the date of the illness or injury?___/___/___ When did your symptoms begin?___/___/___

Did your symptoms develop? ❑ Gradually or ❑ Suddenly How long do symptoms last?______________

Is there a pattern to when your symptoms occur? ❑ Yes ❑ No

if yes, what is the pattern? ❑ In the morning ❑ Occasionally ❑ During sleep

❑ In the evening ❑ Intermittently ❑ Upon waking

❑ All day ❑ Constantly ❑ Other______________

____

What initiates your symptoms?____

What makes them worse?____

What makes them better?____

Have you received treatment for this concern? ❑ yes ❑ no

If yes, what was done and did it help?____

Do you have specific questions you would like to discuss today?______________________

____

____

Family History

Father ❑ Living Age_______ ❑ Deceased Age at Death_______ Cause____________________

Mother ❑ Living Age_______ ❑ Deceased Age at Death_______ Cause____________________

Spouse ❑ Living Age_______ ❑ Deceased Age at Death_______ Cause____________________

Siblings Gender________________ Health Status____________________

Gender________________ Health Status____________________

Children Gender________________ Health Status____________________

Gender________________ Health Status____________________

Check illness(es) which have occurred in any of your blood relatives

❑ Alcoholism ❑ Bleed Easily ❑ Diabetes ❑ Heart Disease ❑ Kidney Disease ❑ Obesity ❑ Allergy ❑ Cancer
❑ Epilepsy ❑ High Blood Pressure ❑ Mental Illness ❑ Stroke ❑ Other____________________

Personal History

How would you describe your health as a child?____________________

____

Check any illnesses or conditions you have had in the past.

❑ Alcoholism	❑ Hepatitis	❑ Pacemaker
❑ Allergies	❑ High Blood Pressure	❑ Pneumonia
❑ Antibiotic Use	❑ High Fevers	❑ Polio
❑ Asthma	❑ HIV/AIDS	❑ Stroke
❑ Bleed Easily	❑ Jaundice	❑ Thyroid Disorders
❑ Cancer	❑ Kidney Disease	❑ Tuberculosis
❑ Chicken Pox	❑ Measles	❑ Typhoid Fever
❑ Diabetes	❑ Meningitis	❑ Ulcers
❑ Epilepsy	❑ Mental Disorder	❑ Vascular Disease
❑ Glaucoma	❑ Multiple Sclerosis	❑ Venereal Disease
❑ Heart Disease	❑ Mumps	❑ Other: ____________

List illnesses not requiring surgery for which you have been hospitalized____________________

____

List illnesses requiring surgery (include dates)____________________

____

List any other serious injury, broken bones, scars, etc.____________________

____

List allergies or sensitivities to medications or other substances____________________

____

List date and results of last medical test (ie: physical, cholesterol, hepatitis, mammography, stool, HIV test, PSA (prostate), Pap smear, or other)

Date____/_____/____ Test________________ Result____________________

Date____/_____/____ Test________________ Result____________________

Date____/_____/____ Test________________ Result____________________

Date____/_____/____ Test________________ Result____________________

Anything else you would like to tell us?____________________

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