Stress Resilience Group Acupuncture at Align: Yoga, Rocks, & Reiki with Kelly Sherman L.Ac., CHN.

Health History Questionnaire and Registration

Patient Information

Today's date____/____/_____

Name_____
(first) (middle) (last)

Birth date____/____/_____ Age _____

Current Gender identity (optional):_____

_____

Preferred pronoun(s) _____

Sex Assigned at Birth: _____

Occupation _____

How did you hear about us? _____

_____

Contact Information

Address_____

City_____State_____Zip_____

Cell phone _____

Work phone _____

Other/home phone_____

Email _____

Another person we may contact if needed:

Name _____

Relationship_____

Cell phone _____

Health History

What are the primary ways you notice stress effects you? (mental/emotional/physical symptoms):

1_____

_____

2_____

_____

How is your sleep? _____

How is your digestion? _____

List medications or food supplements you are taking.

_____

_____

_____

_____

List serious illnesses, accidents or surgeries.

_____

_____

Check symptoms you have or have had in the last year:

- □ Depression
- □ Difficulty in focusing
- □ Dizziness
- □ Easily startled
- □ Excessive worry
- □ Excessive anger
- □ Excessive fear
- □ Fatigue/tiredness
- □ Headaches
- □ Loss of sleep/poor sleep
- □ Loss or gain of weight
- □ Nervousness/irritability
- □ Overwhelmed by life

Check conditions you have or have had in the past:

- □ AIDS
- □ Allergies
- □ Anemia
- □ Arthritis
- □ Bleeding disorders
- □ Breast lump
- □ Cancer
- □ Diabetes

How long has it been since you have had a complete medical exam? _____

Check illnesses that have occurred in blood relatives
. ___ Diabetes ___ Stroke ___ High blood pressure ___ Cancer ___ Heart disease ___ Kidney disease

HEALTH HISTORY… (CONTINUED)

Check symptoms you have or have had in the last year:

MUSCLE/JOINT/BONES

- □ Tremors or Cramps
- □ Swollen joints

Pain, weakness, numbness in:

- □ Arms or Hips
- □ Back or Legs
- □ Feet
- □ Neck
- □ Hands
- □ Shoulders
- □ Other_____

EYES/EAR/NOSE/THROAT/RESPIRATORY

- □ Asthma/wheezing
- □ Blurred or failing vision
- □ Difficulty breathing
- □ Earache
- □ Enlarged glands
- □ Eye pain
- □ Frequent colds
- □ Hay fever
- □ Hoarseness
- □ Gum trouble
- □ Nose bleeds
- □ Loss of hearing
- □ Persistent cough
- □ Ringing in ears
- □ Sinus problems

SKIN

- □ Boils
- □ Bruise easily
- □ Dry skin
- □ Itching/rash
- □ Sensitive skin
- □ Sore won't heal
- □ Sweats

GENITO/URINARY

- □ Blood/pus in urine
- □ Frequent urination
- □ Inability to control urine
- □ Kidney infection/stones
- □ Lowered libido

CARDIOVASCULAR

- □ Chest pain
- □ Hardening of arteries
- □ High or low blood pressure
- □ Pain over heart
- □ Poor circulation
- □ Previous heart attack
- □ Rapid/irregular heart beat
- □ Swelling of ankles

GASTROINTESTINAL

- □ Belching, gas or bloating
- □ Colon trouble
- □ Constipation
- □ Diarrhea
- □ Difficulty swallowing
- □ Distention of abdomen
- □ Excessive hunger
- □ Gall bladder trouble
- □ Hemorrhoids (piles)
- □ Indigestion
- □ Nausea
- □ Pain over stomach
- □ Poor appetite
- □ Vomiting

IF APPLICABLE:

- □ Erection difficulties
- □ Penis discharge
- □ Prostate trouble
- □ Bleeding between periods
- □ Clots in menses
- □ Excessive menstrual flow
- □ Extreme menstrual pain
- □ Irregular cycle
- □ Menopausal symptoms
- □ PMS
- □ Previous miscarriage
- □ Scanty menstrual flow

Could you be pregnant?_____

SIGNATURE

The information on this form is correct to the best of my knowledge.

Signature_____ **Date**_____