Anew Healing LLC

Health History Questionnaire and Registration

Please fill out both sides

PATIENT INFORMATION	
Name	Today's Date
Address	Primary Phone
	Other Phone
Birthdate	Email
Occupation	Emergency Contact:
Primary Physician Phone	Name Relationship Phone E-mail
How did you hear about us?	
Have you had acupuncture before?	

HEALTH HISTORY	
What are your primary concerns for coming in for treatment? 1. _____ 2. _____ 3.	What medications are you taking?
Check symptoms you have now or have had *in the last year*: ☐ Depression ☐ Difficulty Focusing ☐ Dizziness ☐ Easily Startled ☐ Excessive Worry ☐ Excessive anger ☐ Excessive fear ☐ Fatigue/Tiredness ☐ Headaches ☐ Loss of sleep ☐ Weight loss/gain ☐ Nervous/Irritable ☐ Overwhelmed by life	What vitamins or supplements are you taking? Do you sleep well? How is your digestion?
Check symptoms you have now or have had *at any time in the past* ☐ HIV/AIDS ☐ Allergies ☐ Anemia ☐ Arthritis ☐ Bleeding Disorders ☐ Breast Lump ☐ Cancer ☐ Diabetes ☐ Hepatitis ☐ High Blood Pressure ☐ Seizure ☐ Stroke	Please list any serious illnesses, accidents or surgeries with approximate year
When was your last complete physical exam?	Check conditions that have occurred in *blood relatives:* ☐ Diabetes ☐ High Blood Pressure ☐ Cancer ☐ Heart Disease ☐ Stroke ☐ Kidney Disease

HEALTH HISTORY, CONTINUED…

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

MUSCLES/JOINTS/BONES

- ☐ Tremor
- ☐ Cramps
- ☐ Swollen Joints
- ☐ Loss of Control

Pain, weakness or numbness in:

- ☐ Arms
- ☐ Back
- ☐ Feet
- ☐ Hands
- ☐ Hips
- ☐ Knees
- ☐ Neck
- ☐ Shoulders
- ☐ Other:

CARDIOVASCULAR

- ☐ Artery Disease
- ☐ Blood clots
- ☐ Chest pain
- ☐ Fainting
- ☐ Hardening arteries
- ☐ Irregular heartbeat
- ☐ Pacemaker
- ☐ Pain over heart
- ☐ Palpitations
- ☐ Poor circulation
- ☐ Previous heart attack
- ☐ Rapid heartbeat
- ☐ Swollen ankles/legs
- ☐ Other:

EYES/EARS/NOSE/THROAT/RESPIRATORY

- ☐ Asthma/wheezing
- ☐ Bronchitis
- ☐ Cough
- ☐ Blurry vision
- ☐ Difficulty breathing
- ☐ Earache
- ☐ Enlarged glands
- ☐ Eye pain/strain
- ☐ Facial pain
- ☐ Frequent colds
- ☐ Gum disease
- ☐ Hay fever
- ☐ Hearing loss
- ☐ Hoarseness
- ☐ Nosebleeds chronic
- ☐ Ringing in ears
- ☐ Sinus problems
- ☐ TMJ
- ☐ Other

DIGESTION AND ELIMINATION

- ☐ Acid regurgitation
- ☐ Belch, gas, bloating
- ☐ Colitis
- ☐ Constipation
- ☐ Crohn's Disease
- ☐ Diarrhea
- ☐ Difficult swallowing
- ☐ Excess hunger
- ☐ Excess thirst
- ☐ Gallbladder trouble
- ☐ Heartburn
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Nausea
- ☐ Pain over stomach
- ☐ Poor appetite
- ☐ Rectal pain, itching
- ☐ Vomiting
- ☐ Other

SKIN and HAIR

- ☐ Acne
- ☐ Boils
- ☐ Bruise easily
- ☐ Dry skin
- ☐ Eczema
- ☐ Fungal infection
- ☐ Hair loss
- ☐ Hives
- ☐ Itching/rash
- ☐ Psoriasis
- ☐ Sensitive skin
- ☐ Sore won't heal
- ☐ Sweats
- ☐ Other:

NEUROLOGICAL

- ☐ Blackouts
- ☐ Tics
- ☐ Neuropathy
- ☐ Vertigo/Dizziness
- ☐ Other

MEN ONLY

- ☐ Discharge
- ☐ Erection problems
- ☐ Genital pain
- ☐ Prostate problem
- ☐ Other

GENITOURINARY

- ☐ Blood/pus in urine
- ☐ Decreased libido
- ☐ Difficult urination
- ☐ Frequent urination
- ☐ Increased libido
- ☐ Kidney infection
- ☐ Kidney stones
- ☐ Painful intercourse
- ☐ Painful urination
- ☐ Unable to control urine
- ☐ Other

WOMEN ONLY

- ☐ PMS
- ☐ Clots
- ☐ Irregular cycle
- ☐ Missed periods
- ☐ Heavy menstrual flow
- ☐ Painful periods
- ☐ Bleeding between periods
- ☐ Extreme menstrual pain
- ☐ Scanty menstrual flow
- ☐ Previous miscarriage
- ☐ Trying to get pregnant
- ☐ Could you be pregnant?
- ☐ Pregnancy related symptoms
- ☐ Menopause-related symptoms
- ☐ Other

ANY PRIOR EMOTIONAL TRAUMAS? /DID WE MISS ANYTHING ELSE YOU'D LIKE TO SHARE ?