



LIVING
POINTS

Community Acupuncture Clinic

“Acupuncture for Everyone”

5 Allen Ave., Asheville NC 28803

www.livingpoints.net

828-687-8747

<http://www.facebook.com/LivingPoints>

Registration Form / Health History Questionnaire

NAME _____

ADDRESS _____

TELEPHONE# _____ EMAIL _____

DATE OF BIRTH ___/___/___ OCCUPATION _____

EMERGENCY CONTACT _____ RELATIONSHIP _____

EMERGENCY CONTACT TELEPHONE # _____

SIGNATURE _____ TODAYS DATE ___/___/___

What are your primary reasons for coming in for treatment?

- 1.
- 2.
- 3.

How is your sleep? _____

How is your digestion? _____

Medications/Supplements you take: _____

Major Illnesses/Accidents./Surgeries: _____

Do you have access to primary medical care? _____

Do you have difficulty with A) Dealing with stress B) Processing emotions C) Depression or Anxiety

D) Change in your life (either BIG or small)

Do you want support in cutting back on any addictive habits? Y / N

For the following, please check YES for a condition you have currently and PAST for a condition you've had in the past, noting the date in the space provided.

Skin:

Currently Have?	YES	PAST?	When?
Acne, Boils	<input type="checkbox"/>	<input type="checkbox"/>	_____
Acute Hair Loss	<input type="checkbox"/>	<input type="checkbox"/>	_____
Itching/Rash	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other _____	<input type="checkbox"/>	<input type="checkbox"/>	_____

Respiratory System:

Currently Have?	YES	PAST?	When?
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cough	<input type="checkbox"/>	<input type="checkbox"/>	_____
Colds/Flu	<input type="checkbox"/>	<input type="checkbox"/>	_____
Pain in Breathing	<input type="checkbox"/>	<input type="checkbox"/>	_____
Shortness of Breath	<input type="checkbox"/>	<input type="checkbox"/>	_____
Sinus Congestion	<input type="checkbox"/>	<input type="checkbox"/>	_____
Nasal Drainage to Throat	<input type="checkbox"/>	<input type="checkbox"/>	_____
Chest Pains	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other _____	<input type="checkbox"/>	<input type="checkbox"/>	_____

Head, Ear, Eyes, Nose, Throat:

Currently Have?	YES	PAST ?	When?
Head:			
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	_____
Migraines	<input type="checkbox"/>	<input type="checkbox"/>	_____
Head Injury	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>	_____
Ears:			
Earaches	<input type="checkbox"/>	<input type="checkbox"/>	_____
Ringing in Ears	<input type="checkbox"/>	<input type="checkbox"/>	_____
Impaired Hearing	<input type="checkbox"/>	<input type="checkbox"/>	_____
Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	_____
Eyes:			
Eye Pain or Strain	<input type="checkbox"/>	<input type="checkbox"/>	_____
Impaired Vision	<input type="checkbox"/>	<input type="checkbox"/>	_____
Tearing or Dryness	<input type="checkbox"/>	<input type="checkbox"/>	_____
Nose:			
Nose Bleeds	<input type="checkbox"/>	<input type="checkbox"/>	_____
Loss of Smell	<input type="checkbox"/>	<input type="checkbox"/>	_____
Runny/Watery	<input type="checkbox"/>	<input type="checkbox"/>	_____
Congested	<input type="checkbox"/>	<input type="checkbox"/>	_____

Throat:

Goiter	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hoarseness	<input type="checkbox"/>	<input type="checkbox"/>	_____
Swollen Glands	<input type="checkbox"/>	<input type="checkbox"/>	_____
Trouble Swallowing	<input type="checkbox"/>	<input type="checkbox"/>	_____
Neck Pain/Stiffness	<input type="checkbox"/>	<input type="checkbox"/>	_____
Sore Throat	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other _____	<input type="checkbox"/>	<input type="checkbox"/>	_____

Digestive System:

Currently Have?	YES	PAST ?	When?
Nausea/vomiting	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heartburn	<input type="checkbox"/>	<input type="checkbox"/>	_____
Gas or Bloating	<input type="checkbox"/>	<input type="checkbox"/>	_____
Internal Cramping	<input type="checkbox"/>	<input type="checkbox"/>	_____
Constipation	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	_____
Loose Stool	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hemorrhoids	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other _____	<input type="checkbox"/>	<input type="checkbox"/>	_____

Cardiovascular:

Currently Have?	YES	PAST ?	When?
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>	_____
Palpitations/ Fluttering	<input type="checkbox"/>	<input type="checkbox"/>	_____
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	_____
Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	_____
Blood Clots	<input type="checkbox"/>	<input type="checkbox"/>	_____
Ankle Swelling	<input type="checkbox"/>	<input type="checkbox"/>	_____
Fainting	<input type="checkbox"/>	<input type="checkbox"/>	_____
Easily Fatigued	<input type="checkbox"/>	<input type="checkbox"/>	_____
Pace Maker	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other _____	<input type="checkbox"/>	<input type="checkbox"/>	_____

Urinary Tract:

Currently Have?	YES	PAST ?	When?
Frequent Infection	<input type="checkbox"/>	<input type="checkbox"/>	_____
Frequent Urination	<input type="checkbox"/>	<input type="checkbox"/>	_____
Inability to Hold Urine	<input type="checkbox"/>	<input type="checkbox"/>	_____
Burning/Pain or Blood	<input type="checkbox"/>	<input type="checkbox"/>	_____
Kidney Stones	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other _____	<input type="checkbox"/>	<input type="checkbox"/>	_____

Musculoskeletal:

Currently Have?	YES	PAST?	When?
Weakness	<input type="checkbox"/>	<input type="checkbox"/>	_____
Muscle Spasms or Cramps	<input type="checkbox"/>	<input type="checkbox"/>	_____
Joint Pain, Swelling, or Stiffness	<input type="checkbox"/>	<input type="checkbox"/>	_____
Sciatica	<input type="checkbox"/>	<input type="checkbox"/>	_____
Fibromyalgia	<input type="checkbox"/>	<input type="checkbox"/>	_____
Broken Bones	<input type="checkbox"/>	<input type="checkbox"/>	_____
Any Other Pain	<input type="checkbox"/>	<input type="checkbox"/>	_____
Location: _____			
Other _____	<input type="checkbox"/>	<input type="checkbox"/>	_____

Other:

Currently Have?	YES	PAST	When?
Thyroid/endocrine Disorders	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Autoimmune disorders	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other _____			

REPRODUCTIVE, IF APPLICABLE:

Do you now, or have you ever had...? When?

Male:

Testicular Masses	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____
Testicular Pain	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____
Prostate Trouble	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____
Erection Difficulties	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____

Female:

Breast Lumps	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____
Nipple Discharge	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____
Fibroids or ovarian cysts	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____
Irregular Cycle	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____
No Cycle	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____
PMS Symptoms	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____
Pain with Intercourse	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____
Painful Menses	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____
Clotting during menses	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____
Bleeding between periods	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____
Fertility difficulties	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____
Hot Flashes	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____
Vaginal Dryness/Itch	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____
Other _____	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____
Could you be pregnant?	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____

First Treatment Notes

S

O

Tongue

Pulse

A

P

Left

Right