The Healing Point, LLC
Cindy Lawrence, M.AOM, L.Ac.
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Health History

Full Name:			**Date:**
Date of Birth:	**Age:**	**Height:**	**Weight:**
Adress:	**City/State:**		**Zip:**
Home Phone:	**Work Phone:**		
Cell Phone:	**Email:**		
Emergency Contact:	**Emergency Phone:**		
Occupation:	**Employer:**		

Referred by: ____
Have you had acupuncture before? □ yes □ no
If yes, for what condition and when? ____

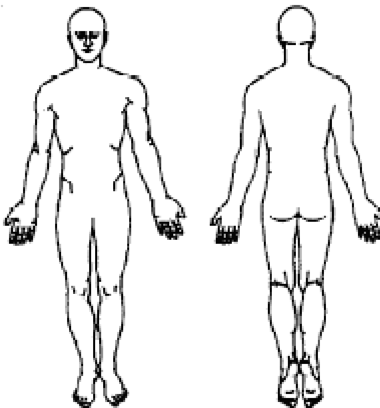
Please list the concern(s) that have brought you here today:
Date of onset

____ ____________________________________
____ ____________________________________
____ ____________________________________
____ ____________________________________

Have you previously been treated for any of these symptoms? □ yes □ no
What was the result? ____
What time of the day do you feel the worst? ____________________ Best? ___________________________

Please mark the areas of discomfort or pain on the figures below using the symbol that best describes what you are feeling.

+++ sharp/stabbing ooo pins and needles vvv dull or aching / / / numbness



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Are you currently under the care of a medical doctor or other health care provider? ☐ yes ☐ no
Name of doctor: ______________________________ Phone #: ________________________
Please list any medications you are taking.
Medication Dosage Reason Date Started
____
____
____

What dietary supplements and/or herbs do you regularly take? ___________________________
____
Please list any allergies: ____
Have you ever had an overnight stay in a hospital or a surgical procedure of any kind?
Event: ____ Date: _______________
Event: ____ Date: _______________

Please describe any that apply.

	Personal History	**Family History**
Heart disease		
High blood pressure		
Autoimmune disorder		
Arthritis		
Diabetes		
Congenital disorder		
Thyroid disorder		
Kidney disease		
Liver disease		
Respiratory disorder		
Neurological disorder		
Gastrointestinal disorder		
Venereal disease		
AIDS		
Mental illness		
Seizure disorder		
Other (please specify)		

What is your stress level on a scale of 1-10 (1 minimum, 10 maximum)? _____________
Do you sleep well? ☐ yes ☐ no What are your normal sleeping hours ? ____________ to ____________
Please check the boxes which best describe your digestion:
☐ Good ☐ Indigestion ☐ Constipation ☐ Diarrhea ☐ Poor appetite
☐ Cravings (type) ______________________________

Please describe your typical diet:
Breakfast: ____
Lunch: ____
Dinner: ____
Snacks: ____

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How many caffeinated drinks do you have per week? ____
How many alcoholic drinks do you have per week? ____
Do you smoke? ☐ yes ☐ no If so, how many per day? ____
Do you exercise? ☐ yes ☐ no If yes, please describe activity: _____________________________________
How many days per week? _____________ How many minutes per session? _________________________

Please check any of the following that apply.

☐ Low back pain and/or weakness
☐ Achy and/or weak knees
☐ Frequent urination
☐ Incontinence
☐ Dark, scanty urine
☐ Night sweats
☐ Hot flashes
☐ Hot hands and feet
☐ Vaginal dryness
☐ Scanty cervical mucus

☐ Cold hands and feet
☐ Cold feeling of lower back and knees
☐ Weak legs
☐ Night time urination
☐ Copious, clear urination
☐ Early morning loose bowel movement
☐ Water retention or edema of legs
☐ Lassitude
☐ Lower back pain premenstrually
☐ Profuse vaginal discharge

☐ Depression/irritability
☐ Fluctuation of mental state
☐ Sighing
☐ Abdominal distension
☐ Borborygmi

☐ Hypochondriac pain
☐ Tinnitus
☐ PMS
☐ Irregular menstruation
☐ Painful periods

☐ Anxiety
☐ Insomnia
☐ Restlessness

☐ Heart palpitations
☐ Disturbing dreams
☐ Fidgeting

☐ Low energy/fatigue
☐ Fatigue after eating
☐ Bloating after eating
☐ Loose stools
☐ Bruise easily
☐ Crave sweets
☐ Uterine prolapsed

☐ Acid reflux
☐ Sour belching
☐ Mouth sores
☐ Nausea/vomiting
☐ Constipation
☐ Increased appetite
☐ Spotting before menses

☐ Asthma
☐ Allergies
☐ Shortness of breath

☐ Prone to catching colds
☐ Chronic sinus congestion
☐ Dry skin

☐ Pale complexion
☐ Dry and flakey skin
☐ Brittle finger and toenails
☐ Thin, dry and/or brittle hair
☐ Scanty and/or late menses

☐ Dark complexion
☐ Varicose or spider veins
☐ Hemangiomas
☐ Numbness of extremities
☐ Mid-cycle pain

☐ Heaviness of body and head
☐ Sticky taste in mouth
☐ Generalized joint aches
☐ Excess weight

☐ Prone to yeast infections
☐ Difficult and cloudy urination
☐ White sticky vaginal discharge
☐ Fibrocystic breasts

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Menstrual History

Age when menses began: ___________ Date of last menstrual period: _____________________
How many days are your cycles? ___________ How many days do you bleed? ______________
On what day do you ovulate? ______________
Are your periods regular? □ yes □ no
How heavy is the bleeding? □ Light □ Medium □ Heavy
What color is the blood? □ pale red □ bright red □ dark red □ purple □ brown
Are there clots? □ yes □ no If yes, what size? □ small □ large
Please check the box that best describes your period:
□ Scant, thin, red □ Heavy, dark, clotted □ Normal red flow

Do you spot between your periods? □ yes □ no
Do you experience pain during ovulation? □ yes □ no
Do you regularly get yeast infections? □ yes □ no
Do you experience chronic vaginal discharge? □ yes □ no

Do you experience PMS? □ yes □ no When? ____
What are your symptoms?
□ irritability □ bloating □ cramping □ breast tenderness □ low back pain □ headaches □ acne
□ digestive upset

Are you currently pregnant? □ yes □ no

Number of pregnancies: _________ Number of births: _________ Number of abortions: __________
Number of miscarriages: _________ Number of D & C's: _________

Date of last pap smear: ________________
Have you ever had an abnormal pap smear? □ yes □ no

Have you ever had any of the following?
□ cervical biopsy □ cauterization □ conization
Have you ever been diagnosed with any of the following STDs?
□ Chlamydia □ gonorrhea □ herpes □ syphilis □ other
When were you diagnosed? __________________ Was it treated? ________________________

Have you ever been diagnosed with any of the following?
□ Polycystic ovary syndrome (PCOS) □ Endometriosis □ Uterine polyps
□ Uterine fibroids □ Pelvic adhesions □ Pelvic inflammatory disease □ Pelvic abnormalities

Do you experience milk or discharge from your breasts? □ yes □ no

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Fertility History

How long have you been trying to conceive? ___________________________
Have you ever been given a diagnosis regarding the infertility? ☐ yes ☐ no
If yes, what was the diagnosis? ____

Have you ever had fertility treatments? ☐ yes ☐ no If yes, please list treatments below.
Treatment Date
____
____
____
____
____
____

Have you taken any fertility medications? ☐ yes ☐ no If yes, please list medication below.
Medication Date Length of time
____
____
____

What fertility procedure are you currently undergoing?
____

Have you had any tubal operations? ☐ yes ☐ no
Have you had your fallopian tubes evaluated or had a hysterosalpingogram (HSG)? ☐ yes ☐ no
If yes, what were the results? ____
Have you had your hormone levels tested? ☐ yes ☐ no If yes, what were the results?
____

Have you ever used any type of birth control? ☐ yes ☐ no If so, what kind?
____
When did you last use birth control? ____
How is your libido? ☐ low ☐ normal ☐ high
Do you use lubricants? ☐ yes ☐ no
Do you douche regularly? ☐ yes ☐ no

Have you been exposed to any known environmental toxins? ☐ yes ☐ no

Has your partner had his reproductive status evaluated by a physician? ☐ yes ☐ no

I certify that the above information is true and correct to the best of my knowledge.

Signature: ____ Date: ________________