

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

Health History

Full Name:		Date:	
Date of Birth:	Age:	Height:	Weight:
Address:		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

_____	_____
_____	_____
_____	_____

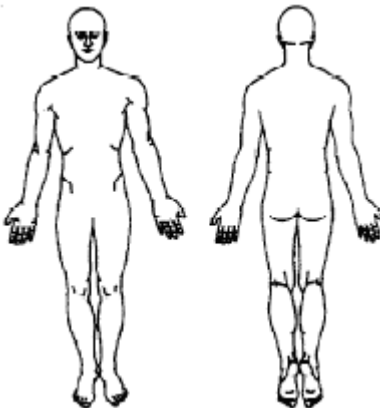
Have you previously been treated for any of these symptoms? yes no

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.

- | | |
|--|---|
| <input type="checkbox"/> Low back pain and/or weakness | <input type="checkbox"/> Cold hands and feet |
| <input type="checkbox"/> Achy and/or weak knees | <input type="checkbox"/> Cold feeling of lower back and knees |
| <input type="checkbox"/> Frequent urination | <input type="checkbox"/> Weak legs |
| <input type="checkbox"/> Incontinence | <input type="checkbox"/> Night time urination |
| <input type="checkbox"/> Dark, scanty urine | <input type="checkbox"/> Copious, clear urination |
| <input type="checkbox"/> Night sweats | <input type="checkbox"/> Early morning loose bowel movement |
| <input type="checkbox"/> Hot flashes | <input type="checkbox"/> Water retention or edema of legs |
| <input type="checkbox"/> Hot hands and feet | <input type="checkbox"/> Lassitude |
| <input type="checkbox"/> Vaginal dryness | <input type="checkbox"/> Lower back pain premenstrually |
| <input type="checkbox"/> Scanty cervical mucus | <input type="checkbox"/> Profuse vaginal discharge |
|
 | |
| <input type="checkbox"/> Depression/irritability | <input type="checkbox"/> Hypochondriac pain |
| <input type="checkbox"/> Fluctuation of mental state | <input type="checkbox"/> Tinnitus |
| <input type="checkbox"/> Sighing | <input type="checkbox"/> PMS |
| <input type="checkbox"/> Abdominal distension | <input type="checkbox"/> Irregular menstruation |
| <input type="checkbox"/> Borborygmi | <input type="checkbox"/> Painful periods |
|
 | |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Heart palpitations |
| <input type="checkbox"/> Insomnia | <input type="checkbox"/> Disturbing dreams |
| <input type="checkbox"/> Restlessness | <input type="checkbox"/> Fidgeting |
|
 | |
| <input type="checkbox"/> Low energy/fatigue | <input type="checkbox"/> Acid reflux |
| <input type="checkbox"/> Fatigue after eating | <input type="checkbox"/> Sour belching |
| <input type="checkbox"/> Bloating after eating | <input type="checkbox"/> Mouth sores |
| <input type="checkbox"/> Loose stools | <input type="checkbox"/> Nausea/vomiting |
| <input type="checkbox"/> Bruise easily | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Crave sweets | <input type="checkbox"/> Increased appetite |
| <input type="checkbox"/> Uterine prolapsed | <input type="checkbox"/> Spotting before menses |
|
 | |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Prone to catching colds |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Chronic sinus congestion |
| <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Dry skin |
|
 | |
| <input type="checkbox"/> Pale complexion | <input type="checkbox"/> Dark complexion |
| <input type="checkbox"/> Dry and flakey skin | <input type="checkbox"/> Varicose or spider veins |
| <input type="checkbox"/> Brittle finger and toenails | <input type="checkbox"/> Hemangiomas |
| <input type="checkbox"/> Thin, dry and/or brittle hair | <input type="checkbox"/> Numbness of extremities |
| <input type="checkbox"/> Scanty and/or late menses | <input type="checkbox"/> Mid-cycle pain |
|
 | |
| <input type="checkbox"/> Heaviness of body and head | <input type="checkbox"/> Prone to yeast infections |
| <input type="checkbox"/> Sticky taste in mouth | <input type="checkbox"/> Difficult and cloudy urination |
| <input type="checkbox"/> Generalized joint aches | <input type="checkbox"/> White sticky vaginal discharge |
| <input type="checkbox"/> Excess weight | <input type="checkbox"/> 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

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

Signature: _____ Date: _____