URDAroma Acupuncture Pain Care

1980 NW Copper Oaks Cir Blue Springs MO 64015, Tel. 816-622-8496, Email. acupuncturepaincare@yahoo.com

Comprehensive Health History Form

Patient Information

Name__________________________Date___________.

Address____City______________ State_____Zip________________

Cell: Work phone: Home phone:

E-mail: Have you had acupuncture before? ( )Yes ( )No

Height: Weight: Age: Sex: ( )Male ( )Female Date of birth____________________

Occupation____

In emergency notify(name): Emergency phone number:

Marital Status: ( )Single ( )Married ( )Other

Number of children: Ages of children:

Primary Care Doctor Last seen:

How did you hear about URDAroma clinic of Oriental Medicine: ( )A Talk ( )Article ( )Yellow Pages ( )Brochure ( )Business Card ( )Web site ( )Newspaper ( )Referred by:

Insurance

Insurance Name____Insurance Group Number_____________________

PrimaryInsured Name____Primary ID Number_________________________

PrimaryInsured DOB________________________. Patient's relationship to Primary Insured: Self / Spouse / Child / Other

(Car accident) •Date:_______________________ •Claim No:____

•Insurance company:____

.Medical History

Reason for your visit here today:____

Are you being treated for this condition by anyone else: ( )Yes ( )No

If Yes, who? Phone number:

Has this condition been diagnosed by a MD? ( )Yes (Diagnosis:) No( )

Have these treatments helped? ( )Yes ( )Somewhat ( )Not much ( )Not at all

How does this condition affect you? How long have you had this condition?

Do you currently have any infectious diseases? ( )Yes ( )No ( )Possibly

If Yes, please identify: ( )HIV+ ( )Hepatitis B ( )Hepatitis C ( )Flu/Cold ( )Streptococcus ( )Mononucleosis ( )Tuberculosis ( )Other:

Known or suspected allergies:

Childhood diseases you have had: ( )Chicken Pox ( )Measles ( )Mumps ( )Rheumatic Fever ( )Diphtheria ( )Scarlet Fever ( )Other:

Physical or Emotional Traumas / Accidents / Hospitalizations / Surgeries in the past 10 years:

Reason ____ Date/Year(s)____

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Health Inventory

Cardiovascular Conditions:	**Emotional / Mental:**	**Energy & Immunity:**	**Respiratory:**
( ) A Pacemaker ( ) Heart Disease ( ) High Blood Pressure ( ) Low Blood Pressure ( ) Chest Pain ( ) Palpitation ( ) Stroke ( ) Varicose Veins ( ) Edema ( ) Cholesterol	( ) Clinical Depression ( ) Mild Depression ( ) ADD or ADHD ( ) Schizophrenia ( ) Mood Swings ( ) Panic Attacks ( ) Nervousness ( ) Anxiety ( ) Alzheimer's ( ) Dementia	( ) Metal Allergy ( ) Chronic Fatigue Syndrome ( ) General Fatigue ( ) Slow Wound Healing ( ) Easy Bruising ( ) Chronic Infections ( ) Frequent Allergies ( ) Shingles/Herpes zoster	( ) Pneumonia ( ) Asthma ( ) Frequent Common Colds ( ) Difficulty Breathing ( ) Emphysema ( ) Persistent Cough ( ) Pleurisy ( ) Tuberculosis ( ) Shortness of Breath
Musculo-Skeletal: ( ) Neck / Shoulder Pain ( ) Muscle Spasms / Cramps ( ) Arm, Wrist Pain ( ) Upper Back Pain ( ) Low Back Pain ( )Sciatic Neuralgia(Hipgout) ( ) Herniated Disk ( ) Hip Bone Pain ( ) Leg Pain ( ) Osteoporosis ( ) Arthritis ( ) Joint Pain ( ) Rheumatoid Arthritis ( ) Facial Paralysis ( ) Ankle(sprain)	**Head, Eye, Ear, Nose & Throat:** ( ) Impaired Vision ( ) Eye Pain/Strain ( ) Glaucoma ( ) Glasses / Contacts ( ) Tearing / Dryness ( ) Impaired Hearing ( ) Ear Ringing ( ) Earaches ( ) Ear Infections ( ) Headaches, ( )Migraine ( ) Sinus Problems ( ) Nose Bleeds ( ) Teeth Grinding ( ) Frequent Sore Throats ( ) TMJ / Jaw Problems ( ) Hay Fever	**Genito-Urinary Tract:** ( ) Kidney Disease ( ) Kidney Stones ( ) Painful Urination ( ) Dribbling Urination ( ) Frequent UTI ( ) Frequent Urination ( ) Blood in Urine ( ) Discharge ( ) Incontinence **Neurological:** ( ) Vertigo / Dizziness ( ) Paralysis ( ) Numbness / Tingling ( ) Loss of Balance ( ) Seizures / Epilepsy ( ) Dyslexia	**Gastrointestinal:** ( ) Stomach Ulcers ( ) Changes in Appetite ( ) Nausea / Vomiting ( ) Epigastric / Abdominal Pain ( ) Passing Gas ( ) Heart Burn ( ) Esophageal Reflux ( ) Indigestion ( ) Belching ( ) Gall Bladder Disease ( ) Gall Bladder Stones ( ) Hemorrhoids ( ) Constipation ( ) Diarrhea
Endocrine: ( ) Hyperthyroid ( ) Hypothyroid ( ) Diabetes Type I ( ) Diabetes Type II ( ) Hypoglycemia ( ) Night Sweats ( ) Unusual Sweating ( ) Feeling Hot ( ) Feeling Cold ( ) Cold Hand / Feet	**Other:** ( ) Cancer Type: ( ) Fibromyalgia ( ) Lupus ( ) Candida ( ) Anemia ( ) Rashes ( ) Eczema / Hives ( ) Atopic Dermatitis ( ) Hemophilia	**Liver Conditions:** ( ) Hepatitis A ( ) Hepatitis B ( ) Hepatitis C ( ) Cirrhosis of Liver	**Men Only:** ( ) Impotence ( ) Vasectomy Date: ( ) Prostate problems ( ) Testicular Pain / Redness / Swelling ( ) Low libido ( ) Excessive libido ( ) Painful Intercourse ( ) Seminal emissions

Women Only:

Are you **pregnant** right now? ( )Yes ( )No ( )Trying ( )Maybe Method of Birth Control:
Age of first period: Date of last menses: Age of menopause:
Typical length of menses (days): Typical length of cycle(from 1st day to 1st day of menses):
Number of Pregnancies: Births: Abortions: Miscarriages:
Hysterectomy: ( ) Yes ( ) No If yes, date:
Check all that apply: ( )Low libido ( )Excessive libido ( )Painful Intercourse ( )Clotting ( )**Painful Periods**
( )Heavy Flow ( )Scanty Flow ( )Bleeding Between Cycles ( )**Irregular Cycles** ( )Vaginal Discharge
( )Breast Lumps/Tenderness ( )Nipple Discharge ( )**Infertility** ( )**Menopausal Symptoms** ( )Premenstrual Problems

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Medications

Please list all prescription and over the counter medications you are currently taking:

Drug Name	Reason for taking	For how long	Dose	Frequency

Please list all supplements and herbs you are currently taking:

Supplement	Reason for taking	Potency	Frequency

Life style

(Daily amount used within the past 2 months)

Tobacco: ( )Yes ( )No Amount: Alcohol: ( )Yes ( )No Amount:

Coffee: ( )Yes ( )No Amount: Recreational Drug: ( )Yes ( )No Amount:.

Do you feel you are at or near your ideal weight? ( )Yes ( )No

Do you feel you have enough energy? ( )Yes ( )No Are you vegeterian or vegan? ( )Yes ( )No

Best time of day (full of energy): Worst time of day (least energy):

Favorite Season: Hours of sleep / night:

Do you feel rested after a night sleep? Do you remember your dreams?

Typical day's meals:

Breakfast:

Lunch:

Dinner:

Snacks / Other:

Food cravings:

Religion or other spiritual practice:

Hobbies or other recreation:

What kind of physical exercise do you do regularly?

Hours of work per week?

How would you rate your current stress level? ( )Extreme ( )Very High ( )High ( )Moderate ( )Low

Please feel free to express any concerns or thoughts you feel may be relevant to your health below:

URDAroma You Are The Aroma URDAroma Acupuncture Pain Care

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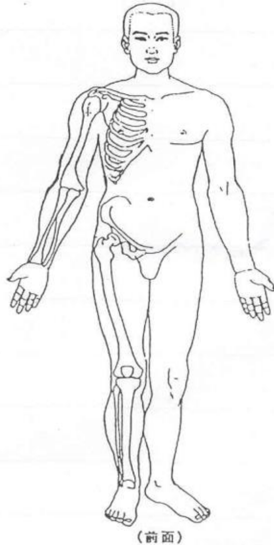
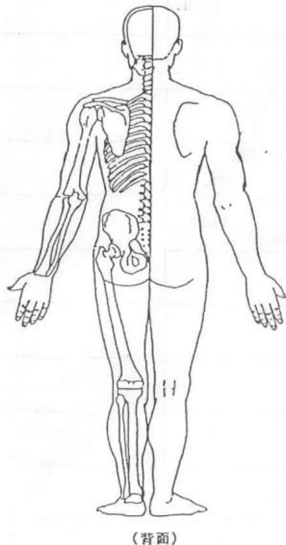
Use the diagram if desired.

How bad is your pain?	0	1	2	3	4	5	6	7	8	9	10
No pain Unbearable pain											





The Above information is true to the best of my knowledge. I understand and accept that I am responsible for full payment of my account and that payment is expected at the time of service. I also understand and accept that I am expected to notify URDAroma Acupuncture Pain Care Clinic of Oriental Medicine **24** hours prior to any cancellations or changes to my appointment times and that if I do not I may be charged for the appointment.

XSigned:______________________________Date:__________________________________.

Parent / Guardian (if applicable).

Would you like to receive a free email newsletter: ( )Yes ( )No