ABDC – ACUPUNCTURE BY DENISE COLLINS

Patient Name: _____ Date: _____

Health History

Name _____ Date _____
Occupation _____Age _____Height _____ Sex___
Marital Status □ Single □ Partner □ Married □ Separated □ Divorced □ Widow (er)
Are you recovering from a cold or flu? _____ Are you pregnant _____
Reason for office visit:
_____

_____

_____

List current health problems for which you are being treated:_____

_____

_____

What types of therapies have you tried for these problem(s) or to improve your health over all:
□ diet modification □ fasting □ vitamins/minerals □ herbs □ homeopathy
□ Chiropractic □ acupuncture □ conventional drugs □ other _____

Do you experience any of these general symptoms EVER DAY?
□ Debilitating fatigue □ Shortness of breath □ Insomnia □ Constipation □Chronic pain/inflammation
□ Depression □ Panic attacks □ Nausea □ Bleeding □ Fecal Incontinence
□ Headaches □ Vomiting □ Diarrhea □ Dizziness □ Urinary Incontinence
□ Low Grade Fever □ Itching/rash
Current medications (prescription or over the counter): _____
_____

_____

Laboratory procedures performed:_____
_____

Outcome: _____
_____

Major Hospitalizations, Surgeries, Injuries: Please list all procedures, complications (if any) and dates:

Year	Surgery, Illness, Injury	Outcome
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Circle the level of stress you are experiencing on a scale of 1 to 10(1 being the lowest) 1 2 3 4 5 6 7 8 9 10
Identify the major causes of stress (e.g. changes in job, work, residence, finances): _____
What are your current health goals: _____
_____