ABDC – Acupuncture By Denise Collins

HEALTH HISTORY

Patient Name ____________________________________ Date _____________

MAIN COMPLAINTS

Please write in your top 3 health complaints / concerns in order of importance to you. Circle the items that make it better or worse and mark on the scale from 1-10 the severity of the condition (1=no symptoms, 10=worst ever)

1 ___________________________________

When did this start? __________________ ago

Heat makes it:	better	no change	worse
Cold makes it:	better	no change	worse
Damp weather:	better	no change	worse
Exercise/Activity:	better	no change	worse

1 |————|————| 10

2 ___________________________________

When did this start? __________________ ago

Heat makes it:	better	no change	worse
Cold makes it:	better	no change	worse
Damp weather:	better	no change	worse
Exercise/Activity:	better	no change	worse

1 |————|————| 10

3 ___________________________________

When did this start? __________________ ago

Heat makes it:	better	no change	worse
Cold makes it:	better	no change	worse
Damp weather:	better	no change	worse
Exercise/Activity:	better	no change	worse

1 |————|————| 10

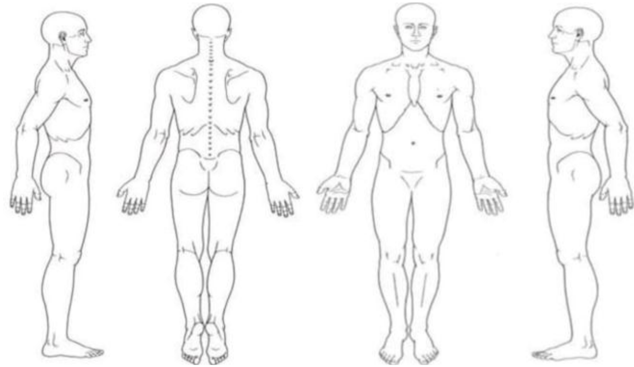
MUSCULOSKELETAL / EXTREMITIES

Pain / Weakness / Numbness in:

□ Head	□ Hands	□ Feet	□ Upper Back
□ Neck	□ Wrists	□ Ankles	□ Mid Back
□ Chest	□ Elbows	□ Knees	□ Lower Back
□ Arms	□ Shoulders	□ Hips	□ Legs

□ Joint Swelling	□ Edema	□ Carpal Tunnel	□ Broken Bones
□ Tendonitis	□ Sprains/Strains	□ Muscle Pain	□ Rotator Cuff
□ Paralysis	□ Bursitis	□ Poor Balance	□ Whole Body Pain
□ Sciatica		□ Restricted Movement	

□ Other _____________________



INJURIES & TRAUMAS (PHYSICAL / EMOTIONAL)

When What Happened?

_____ ____

_____ ____

SURGERIES

When What Surgery?

_____ ____

_____ ____

MEDICATIONS

Please list ALL prescriptions, herbs, and supplements that you take regularly.

____

____

____

CHILDHOOD HEALTH HISTORY

□ Asthma	□ Frequent Earaches	□ Scarlet Fever	□ Forceps Delivery
□ Frequent Cold/Flu	□ Frequent Sore Throat	□ Chicken Pox	□ Premature Birth

□ Other Birth Trauma: ____

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HEALTH HISTORY

Patient Name ______________________________________ Date _____________

HEALTH HISTORY

Check the ☐ if YOU have / had the condition and note the year it started.

Check the ○ if there is a FAMILY MEMBER with history of the condition.

	YOU	Year	FAMILY		YOU	Year	FAMILY
Cancer type(s) ____________________	☐	____	○	Allergies ______________________	☐	____	○
Osteoporosis	☐	____	○	Herpes	☐	____	○
Diabetes	☐	____	○	AIDS/HIV	☐	____	○
Hepatitis	☐	____	○	Other STD	☐	____	○
High Blood Pressure	☐	____	○	Rheumatic Fever	☐	____	○
Heart Disease	☐	____	○	Alcoholism	☐	____	○
Stroke	☐	____	○	Seizure Disorder	☐	____	○
Thyroid Disease	☐	____	○	Mental Illness	☐	____	○
Arthritis	☐	____	○	Kidney Disease	☐	____	○
Diverticulitis / IBS	☐	____	○	Gastritis/Pancreatis	☐	____	○
Hypo/Hyperglycemia	☐	____	○	Emphysema	☐	____	○
Reynaud's Disease	☐	____	○	Elevated Cholesterol	☐	____	○

HABITS

	Amount / Week	*If Quit, When?*
Coffee	__________________________	___________
Tea	__________________________	___________
Soda	__________________________	___________
Tobacco	__________________________	___________
Alcohol	__________________________	___________
Drugs	__________________________	___________

EXERCISE

Do you exercise regularly?

If so, what types?	*What frequency / duration?*
____________________	_______________________
____________________	_______________________
____________________	_______________________
____________________	_______________________

DIET

☐ Low/No Carb ☐ Vegetarian/Vegan ☐ Portion Control ☐ Low Fat ☐ Standard American

Typical Breakfast: ____

Typical Lunch: ____

Typical Dinner: ____

Typical Snacks: ____

DEVICES

Please mark those that you use.

☐ Pacemaker ☐ Contact Lenses ☐ Hearing Aid ☐ Artificial Limb

☐ Birth Control ☐ Eyeglasses ☐ Dentures ☐ Brace (neck, arm, back)

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HEALTH HISTORY

Patient Name ___________________________________ Date _____________

HEAD, EYES, EARS, NOSE, THROAT

□ Migraines	□ Eye Strain	□ Earaches	□ Sinus Problems	□ Dry Lips/Mouth
□ Headaches	□ Eye Pain	□ Poor Hearing	□ Poor Smell	□ Dry Throat
□ Heavy-Headed	□ Red/Itchy Eyes	□ Ear Ringing	□ Nose Bleeds	□ Sore Throats
□ Light-Headed	□ Blurry Vision	□ Excess Ear Wax	□ Enlarged Thyroid	□ Mouth Sores
□ Facial Pain	□ Poor Night Vision	□ Teeth Problems	□ Lumps in Throat	□ Grinding Teeth
□ Sensitive to Light	□ Spots in Eyes	□ Gum Problems	□ Swollen Glands	□ Jaw Lock / Clicks
□ Dizziness	□ Color Blindness	□ Tongue Sores	□ Difficulty Swallowing	
□ Glaucoma	□ Cataracts	□ Excessive Phlegm	□ Excessive Salvia	

CARDIOVASCULAR

□ Shortness of Breath	□ Irregular Heart Beats	□ Blood Clots	□ Bleed / Bruise Easily	□ Phlebitis
□ Slow Heart Rate	□ Palpitations	□ Spontaneous Sweating	□ Chest Pain / Pressure	□ High Blood Pressure
□ Fast Heart Rate	□ Varicose/Spider Veins	□ Fainting	□ Hands/Feet Swelling	□ Low Blood Pressure

RESPIRATORY

□ Cough/Wheezing	□ Pneumonia	□Frequent Colds	□ Bronchitis	□ Chest Tightness
□ Coughing Blood	□Pain on Deep Inhalation	□ Frequent Fevers	□ Phlegm (color: ______________________)	
□ Asthma	□ Difficult Inhale/Exhale	□ Difficulty Breathing when lying down		

GASTROINTESTINAL

□ Indigestion	□ Black Stools	□ Hemorrhoids	□ Hiatal Hernia	□ IBS/Crohn's Disease
□ Bloating	□ Dry Stools	□ Bowel Incontinence	□ Heartburn/Reflux	□ Abdominal Pain
□ Gas	□ Blood in Stool	□ Difficult to Pass	□ Nausea/Vomiting	□ Painful Digestion
□ Belching	□ Rectal Pain	□ Cramps w/ BM	□ Excessive Hunger	□ Poor Appetite
□ Bad Breath	□ Tired after BM	□ Unsatisfying BM	□ Peculiar Taste/Smells	□ Stomachaches

Bowel Movement: How Often? ___ times per day Stools keep shape? Y / N

Diarrhea |—————|—————| Constipation

GENITO-URINARY

□ Clear Urine	□ Scanty Urine	□ Blood in Urine	□ Frequent UTI	□ Prostate Disease
□ Testical Pain	□ Jock Itch	□ Dark Urine	□ Profuse Urination	□ Painful Urination
□ Erectile Dysfunction	□ Decreased Libido	□ Herpes	□ Vasectomy	□ Cloudy Urine
□ Frequent Urination	□ Incontinence	□ Difficult Start/Stop	□ Premature Ejaculation	□ Genital Pain
□ Hernia	□ Burning Urination	□ Urgent Urination	□ Kidney Stones	□ Nocturnal Emission
□ Genital Sores	□ Excess Libido	Wake up to Urinate: ___ times per night		

NEURO-PSYCHO-EMOTIONAL

□ Seizure	□ Nervousness	□ Bi-Polar	□ Seasonal Affective Disorder	□ Angry
□ Concussion	□ Anxiety	□ Poor Memory	□ Poor Concentration	□ Sad
□ Loss of Balance	□ Panic Attacks	□ Forgetful	□ Difficulty Expressing Emotions	□ Grief
□ Vertigo / Dizziness	□ Areas of Numbness	□ Indecision	□ Frequent Sighing/Yawning	□ Overthinking
□ Tremors	□ Irritable	□ ADD/ADHD	□ Lack of Coordination	□ Joy
□ Tics	□ Depression		□ Easily Stressed	□ Fearful

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HEALTH HISTORY

Patient Name ______________________________________ Date _____________

ENERGY

- ☐ Wired
- ☐ Fatigue
- ☐ Dependence on Caffeine
- ☐ Body feels Heavy
- ☐ Energy Drop after Eating
- ☐ Body feels Weak
- ☐ Sudden Energy Drop: Time of Day: ______

LOW |——————|——————|

SLEEP

- ☐ Difficulty Falling Asleep
- ☐ Sleep Walk/Talk
- ☐ Not Rested
- ☐ Difficulty Staying Asleep
- ☐ Disturbing Dreams
- ☐ Excessive Sleep
- ☐ Wake to Urinate
- ☐ Not Enough Sleep
- ☐ Wake _____ X / night
- ☐ Sleep _____ hrs. / night
- ☐ Restless Sleep

GYNECOLOGICAL

- ☐ Vaginal Dryness
- ☐ Endometriosis
- ☐ Cramps
- ☐ Digestive changes w/ Period
- ☐ Length of Cycle: ____ days
- ☐ Vaginal Sores
- ☐ Fibroids
- ☐ Clots
- ☐ Fibrocystic Breast Tissue
- ☐ Length of Menses: ____ days
- ☐ Vaginal Discharge
- ☐ PMS
- ☐ Breasts Tender
- ☐ Polycystic Ovarian Disease
- ☐ Menopause: Age ____
- ☐ Infertility
- ☐ Painful Periods
- ☐ Mood Changes
- ☐ Difficult/Painful Intercourse
- ☐ Number of Pregnancies: ____
- ☐ Irregular Periods
- ☐ Heavy Periods
- ☐ Period Fatigue
- ☐ Age at First Menses: ____
- ☐ Number of Births: ____
- ☐ Ovarian Cysts
- ☐ Light Periods
- ☐ Spotting
- ☐ Date of Last Menses: ____
- ☐ # Abortions/Miscarriages: ___

SKIN, HAIR, & NAILS

- ☐ Rashes
- ☐ Thick Skin
- ☐ Ulcerations
- ☐ Hair Loss
- ☐ Dry Nails
- ☐ Eczema
- ☐ Thin Skin
- ☐ Recent Moles
- ☐ Dry/Brittle Hair
- ☐ Weak Nails
- ☐ Acne
- ☐ Scaly Skin
- ☐ Psoriasis
- ☐ Premature Greying
- ☐ Ridged Nails
- ☐ Face Flushing
- ☐ Dark Under Eyes
- ☐ Dermatitis
- ☐ Dandruff
- ☐ Thin Nails
- ☐ Discolored Skin
- ☐ Dry Skin
- ☐ Itching
- ☐ Change in Hair Texture
- ☐ Nail Fungus
- ☐ Warts
- ☐ Hives
- ☐ Abscesses/Infections
- ☐ Lumps
- ☐ Fungal Infections
- ☐ Bruise Easily
- ☐ Change in Skin Texture
- ☐ Other: ___________________________________

TEMPERATURE & THIRST

- ☐ Cold Hands/Feet
- ☐ Thirst for Cold Drinks
- ☐ Excessive Thirst
- ☐ Hot Flashes
- ☐ Unusual Sweats
- ☐ Cold "In the Bones"
- ☐ Thirst for Hot Drinks
- ☐ Hot Hands
- ☐ Hot in Afternoon – Where on Body: _________
- ☐ Areas of Numbness
- ☐ Thirst, no desire to drink
- ☐ Hot Feet
- ☐ Hot at Night – What Time: ____ am/pm
- ☐ Chills
- ☐ Absence of Thirst
- ☐ Hot Chest
- ☐ Night Sweats

Typical Body Temperature

COLD |——————|——————| HOT

FOR PRACTITIONER USE ONLY – EASTERN DIAGNOSIS

Eight Principle: ❒ Yin ❒ Yang ❒ Interior ❒ Exterior ❒ Cold ❒ Heat ❒ Deficiency ❒ Excess

Zang Fu Dysfunction: ____

Qi Dysfunction: ❒ Deficiency ❒ Sinking ❒ Stagnation ❒ Rebellious

Bl Dysfunction: ❒ Deficiency ❒ Stagnation ❒ Heat ❒ Cold

Pulse: ________________________________ Tongue: ________________________________