Fannie Koa
Lic. Ac., Dipl. O.M., MAOM, MBA

Health History Form

Patient information

First Name:	Last Name:	Cell:
Street:		Home:
City, State:	Zip:	Work:
Birthdate: Age:	Gender:	Email:
Height:	Weight:	Occupation:
Referred by:		

Emergency Contact

Name & Relationship:	Phone Number:
Doctor/Primary Care Physician:	Phone number:

Main Complaint/s

#1:

When did this begin?
Is there a diagnosis?

Have you consulted a physician? Yes / No

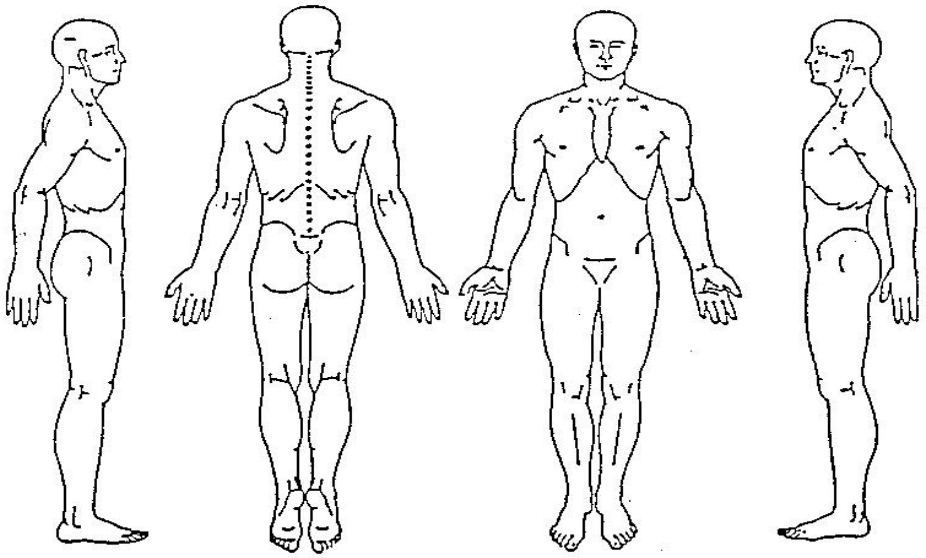
What other types of treatment have you tried?

#2:

When did this begin?
Is there a diagnosis?

Have you tried Chinese Medicine before? Yes / No

Indicate areas of pain



Past Medical History – check all that apply:

❑ Diabetes	❑ Cancer	❑ HIV	❑ Hepatitis	❑ High Blood Pressure	❑ Stroke
❑ Heart disease	❑ Seizures	❑ Autoimmune	❑ Thyroid disease	❑ Prostrate issues	❑ Hysterectomy
❑ Pacemaker	❑ Kidney disease	❑ IBS	❑ Depression	❑ Rheumatic fever	❑ Asthma

List any significant trauma, illnesses, major accidents, severe injuries (include dates/age when it happened):

List any hospitalizations/surgeries (include dates):

List current medications (include prescription, OTC, vitamins, herbs):

Medication	Dosage	Reason for taking

Average Diet

Morning	Afternoon	Evening

Are you on a particular type of diet? Yes / No Please specify:

How much water do you drink in a day?

Do you consume any of the following – check all that apply: (Please indicate how much)

❑ Soda _____ per week ❑ Diet drinks _____ per week ❑ Soy _____ per week
❑ Coffee/tea _____ per day ❑ Dairy _____ per week ❑ Meat _____ per week

Is more than 25% of your diet frozen, canned, boxed or processed foods? Yes / No

Describe your appetite: Too good Just right Not good enough

Lifestyle

Do you smoke? Yes / No If yes, how many cigarettes/cigars per day?

Do you have a regular exercise program? Yes / No
If yes, please describe:

How many hours of sleep do you get on average?
Do you have trouble falling asleep or staying asleep?

Are there areas of your life that you find particularly stressful?

For Women only:

Age of first menses: ___ years old Average length of period: ___ days Average days between periods: ____to ____ days
Are you pregnant? Yes / No Number of pregnancies, if applicable: _____ Live births: _____
Is it possible that you are pregnant? Yes / No
Do you practice birth control? Yes / No If yes, what type? _____ How long? _____
Are you in menopause? Yes / No If yes, since when? _____

Check all that apply:

❑ Irregular cycles ❑ Painful periods ❑ Vaginal discharge ❑ Fibroids ❑ Polycystic ovary syndrome
❑ Scanty flow ❑ Heavy flow ❑ Vaginal sores ❑ Endometriosis ❑ Frequent yeast infections
❑ PMS ❑ Clots ❑ STDs ❑ Ovarian cysts
❑ Cramps ❑ Breast tenderness ❑ Breast lumps ❑ Infertility

Please check any that apply, especially if experienced in the last 3 months

General:

❑ Fevers ❑ Chills ❑ Fatigue ❑ Cravings ❑ Strange tastes or smells
❑ Sweat easily ❑ Night sweats ❑ Poor sleep ❑ Weight loss ❑ Change in appetite
❑ Running warm ❑ Running cold ❑ Sudden energy drop ❑ Weight gain
❑ Strong thirst ❑ Cold hands & feet

Skin & Hair:

❑ Rashes ❑ Itching ❑ Psoriasis ❑ Dry skin ❑ Recent moles
❑ Eczema ❑ Dermatitis ❑ Infection ❑ Brittle nails ❑ Change in hair or skin texture
❑ Hives ❑ Acne ❑ Ulcerations ❑ Hair loss ❑ Discoloration

Head:	**Ears:**	**Eyes**	**Nose**	**Mouth:**
❑ Dizziness	❑ Ear blockage	❑ Floaters/Spots	❑ Sinus congestion	❑ TMJ
❑ Vertigo	❑ Ringing in ears	❑ Poor vision	❑ Post nasal drip	❑ Teeth grinding
❑ Migraines	❑ Hearing loss	❑ Watery eyes	❑ Nose bleeds	❑ Sore throat
❑ Tension headaches		❑ Dry eyes		❑ Itchy throat
❑ Cloudy/Fogginess		❑ Itchy eyes		Dry mouth

Cardiovascular:

❑ Chest tightness	❑ High blood pressure	❑ Fainting	❑ Blood clots	❑ Varicose veins
❑ Irregular heartbeat	❑ Low blood pressure	❑ Swelling in limbs	❑ Peripheral artery disease	

Respiratory:

❑ Cough	❑ Difficulty breathing	❑ Asthma	❑ Phlegm production	Other:
❑ Coughing blood	❑ Wheezing	❑ Short of breath	❑ Pneumonia	

Gastrointestinal:

❑ Nausea	❑ Gas	❑ Diarrhea	❑ Blood in stool	Other:
❑ Vomiting	❑ Bloating	❑ Constipation	❑ Undigested food in stool	
❑ Indigestion	❑ Abdominal pain	❑ Hemorrhoids	❑ IBS	
❑ Acid reflux	❑ Belching	❑ Burning	❑ Celiac disease	

Urinary:

❑ Frequent urination	❑ Incontinence	❑ Frequent UTIs	❑ Weak stream	Other:
❑ Urgency to urinate	❑ Pain upon urination	❑ Dark color	❑ Kidney stones	
❑ Frequent night urination	❑ Blood in urine	❑ Strong odor	❑ Inability to empty bladder	

Male Health:

❑ Impotence	❑ Enlarged prostate	❑ Testicular Pain	❑ Low libido	Other:
❑ Premature ejaculation	❑ Low sperm count	❑ Low motility	❑ STDs	

Musculoskeletal: Indicate where:

❑ Neck pain	❑ Back pain	❑ Joint pain	_____
❑ Tight shoulders	❑ Sciatica	❑ Herniated disc	_____
	❑ Hip pain	❑ Arthritis:	_____

Neurological: Indicate where:

❑ Seizures	❑ Loss of balance	❑ Tremors	❑ Areas of numbness	_____
❑ Concussion	❑ Confusion	❑ Neuropathy	Other:	

Emotions:

❑ Anxiety	❑ Anger	❑ Depression	❑ Fearful
❑ Panic attacks	❑ Insomnia – racing mind	❑ Cloudy/foggy mind	❑ Phobias:

Are you currently being treated for emotional or psychological issues? Yes / No

Have you ever considered or attempted suicide? Yes / No

CONSENT TO TREATMENT

I, _____, hereby authorize Fannie Koa, Licensed Acupuncturist (Lic.Ac.), Diplomate of Oriental Medicine (Dipl.O.M.) to administer treatment of acupuncture, adjunctive techniques and herbal medicine relevant to my diagnosis.

The patient has the right to refuse any form of treatment. I understand that acupuncturists practicing in the state of Massachusetts are not primary care providers and that regular primary care by a licensed physician is an important choice that is strongly recommended.

Treatment may include but is not limited to the following:

1. Insertion of various styles and sizes of acupuncture needles into my body at various depths and locations.
2. Heat treatments using conventional heat lamp or moxibustion (Artemesia Vulgaris). With any heat treatment exists the risk of burn.
3. Massage technique or gua sha. This technique may cause redness on the skin at the sight of treatment that may last approximately 1 – 7 days. Slight bruising and tenderness may persist after the treatment.
4. The placement of suction cups on the skin. These cups may produce a red or purple mark on the skin at the sight of the cup that may last approximately 1 – 7days. Slight bruising and tenderness may persist after the treatment.
5. Electrical stimulation of the needles may be used producing a tapping sensation at the needle location.
6. Herbal medicine, administered in various forms including tablets, capsules, extracts powders, raw herbs, and liniments. These herbs are taken orally and/or topically. Some patients may experience side effects including but not limited to upset stomach or nausea.

I have been informed that I have the right to refuse any form of treatment. I understand the nature of the treatment and have been given the opportunity to ask questions pertaining to the treatment. I also understand there is always a possibility of an unexpected complication and the possible aggravation of symptoms existing prior to acupuncture treatment. I understand that no guarantee can be made concerning the results of treatment.

Signature of Patient or Legal Guardian: _____

Printed name of Patient: _____

Date: _____