Kristin Lundeen ACUPUNCTURE

2101 Defense Highway, Ste A | Crofton, MD21114
(443)584-3047
www.kristinlundeenacupuncture.com

• acupuncture • acupressure • reiki • moxibustion • orthopedic acupuncture • cupping • craniosacral therapy • aricular acupuncture •

HEALTH HISTORY

Name: _____ Today's Date: _____

Address: _____ City: _____

State: _____ Zip: _____ Email Address: _____

Phone Home: _____ Work: _____ Cell: _____

Birth Date: _____ Age: _____ Ht: _____ Wt: _____ Sex: M/F

Marital Status: _____ # of Children: _____ Occupation: _____

Emergency Contact Name: _____ Phone: _____

Primary Care Practitioner: _____

Is this your first time getting acupuncture? Y / N How did you hear about us? _____

Goals: What would you most like to achieve with acupuncture treatments?

_____

_____

_____

Major Symptoms: Please list in order of importance what symptoms are of concern to you. List most concerning to least concerning along with duration of symptoms:

_____

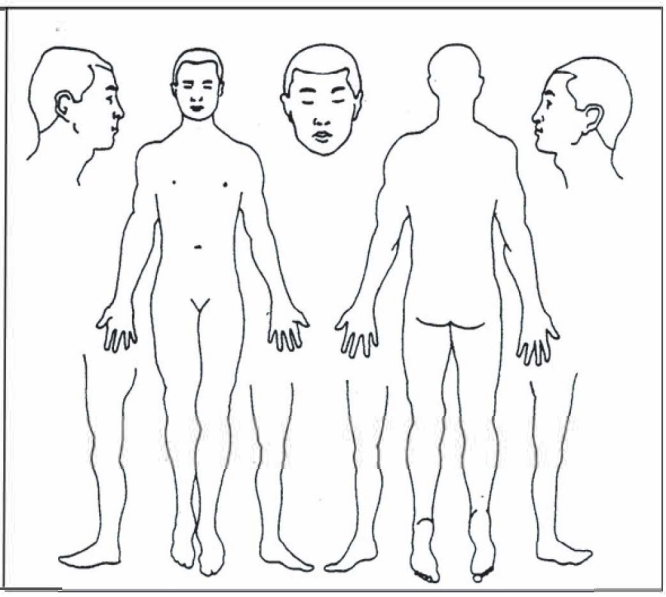
_____

Are you experiencing pain/discomfort in any area of your body? Y / N

Please rate your pain level:
1 2 3 4 5 6 7 8 9 10

Use the illustration at left to indicate painful or distressed areas. Indicate the location of the discomfort by using the symbol that best describes the feeling:

XXX = Sharp/ Stabbing
PPP = Pins & Needles
DDD = Dull/Aching
NNN = Numbness
TTT = Tightness/Spasms



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Medical History

Do you have, or have you ever had, any of the following conditions? If yes, please indicate the date of your diagnosis.

	Date Diagnosed		Date Diagnosed
Cancer: Type_____		HIV	
Diabetes		Mental Illness	
Heart Disease		Seizures	
Hepatitis		Stroke	
High Blood Pressure		Hypothyroid	
High Cholesterol		Hyperthyroid	
Heart Attack		Other: _____	

Please list surgeries or major illnesses with date: _____

_____

_____

_____

Please list any medications or supplements you have taken in the past 2 months: _____

_____

_____

_____

Do you have a pacemaker or any metal devices in your body: Y / N

Family History

Please indicate close family members with any of the following:

	Family Members		Family Members
Cancer: Type_____		Heart Attack	
Diabetes		High Cholesterol	
Heart Disease		Stroke	
High Blood Pressure		Other: _____	

Lifestyle Habits

Do you have an exercise routine? Please describe: _____

_____

How many hours per night do you sleep on average? _____ Do you wake rested? Y / N

Nicotine Use: _____ Alcohol Use (# of drinks/wk & type): _____

Caffeine Use (# of drinks/day and type): _____

Water Intake (how much/day): _____

Dietary habits (# of meals/day and type of food): _____

_____

_____

_____

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Please check all that apply:

Energy and Immunity:
__ Fatigue
__ Allergies (Specify) _____
__ Anemia
__ Chronic Fatigue Syndrome
__ Thyroid Problems
__ Tendency to Catch Colds

Head, Eye, Ear, Nose and Throat:
__ Eye Dryness
__ Blurry Vision
__ Poor Night Vision
__ Ear Ringing
__ Hearing Difficulties
__ Headaches / Migraines
__ Teeth Grinding / TMJ
__ Sore Throat
__ Chronic Sinus Congestion
__ Dry Mouth
__ Bad Breath
__ Mouth Sores / Bleeding Gums
__ Increase in Thirst

Emotions / Sleep:
__ Mood Swings
__ Anxious / Worried
__ Depressed
__ Irritable
__ Difficulty Making Decisions
__ Stressed
__ Insomnia
__ Nightmares
__ Difficulty falling or Staying Asleep

Respiratory / Circulatory
__ Shortness of Breath
__ Asthma
__ Chest Pain
__ Palpitations / Fluttering
__ Poor Circulations (Cold Hands / Feet)
__ Chronic Cough
__ Night Sweats
__ Unusual Sweating
__ Hot/Cold Intolerance

Gastrointestinal
__ Ulcers
__ Changes in Appetite
__ Nausea / Vomiting
__ Bloating / Pain
__ Gas
__ Heartburn / Acid Reflux
__ Belching
__ Hemorrhoids
__ Diarrhea
__ Constipation
__ Sudden Weight Change

Kidney / Urinary:
__ Painful Urination
__ Frequent Urinary Tract Infections
__ Frequent / Urgent Urination
__ Edema / Swelling

Musculoskeletal:
__ Neck / Shoulder Pain
__ Muscle Spasms / Cramps / Weakness
__ Arm Pain
__ Finger Pain / Tingling / Numbness
__ Upper Back Pain
__ Mid Back Pain
__ Low Back Pain
__ Leg / Knee Pain
__ Foot / Ankle Pain
__ Hip / Pelvic Pain
__ Arthritis

Neurological:
__ Vertigo / Dizziness
__ Numbness /Tingling
__ Difficulty Concentrating / Poor Memory

Skin:
__ Rashes / Eczema / Hives / Psoriasis
__ Dry Hair or Hair Loss
__ Changes in Skin Color
__ Easy Bruising
__ Acne
__ Dry / Itchy Skin

Female Health:
__ Irregular Cycle
__ Heavy Flow
__ Light Flow
__ Clots in Menstrual Blood
__ Menstrual Related Moodiness
__ Menstrual Related Breast Tenderness
__ Menstrual Related Bloating
__ Bleeding Between Cycles
__ Painful Periods (Is pain before, during or after your period?)
_____
__ Hot Flashes
__ Vaginal Dryness
__ Breast Lumps / Cysts
__ Uterine Fibroids
__ Endometriosis
__ Ovarian Cysts
__ Unusual Vaginal Discharge Odor
__ Frequent Yeast Infections
__ Decreased Libido

Male Health:
__ Prostate Enlargement
__ Impotence
__ Premature Ejaculation
__ Decreased Libido
__ Groin Pain