Chinese Holistic Health Center LLC
777 Carle Ave, Lewis Center, OH 43035
www.chhc88.com
Fax: 740-201-8173

Name (please print):________________________________ Gender: F ☐ M ☐ Married: ☐ Single: ☐

Date of Birth:_____________ Age_____ Occupation: _______________ Employer: ____________________

Address:______________________ City:______________ State:__________ Zip Code:________________

Phone:(______) _______-________ Email: ___________________________ Height: _____Weight: ______

Emergency Contact: _________________________ Phone: (_____)_______-_______

Primary Physician: __________________ Phone: (_____)_____-_______ Referred by: ________________

Health Insurance Co. __________________

Primary name on insurance card ______________________________________ or self _________

Date of birth of primary name on insurance card _________________

Reason you are seeking acupuncture:____
How long ago did his problem begin?____
Have you been given a diagnosis for this problem? ____
What kinds of treatment have you tried?____

Past Medical History
Bleeding disorder: Yes ☐ No ☐ Blood pressure: ________ Pacemaker or implants: Yes ☐ No ☐
Illnesses: ____
Surgeries:____
Significant Trauma (Auto accidents, falls, etc.)____
Do you have, or have you ever had, any infectious diseases: Yes ☐ No ☐

Medicines: Prescriptions, vitamins taking for what condition?
1. _______________ Taking for _________________ 3. ________________ Taking for _______________
2. _______________ Taking for _________________ 4. ________________ Taking for _______________

Personal History
Stress Level:_______ (Scale of 1-10) Energy Level: _____(Scale of 1-10) Appetite : ☐ Poor ☐ Good
☐ Regular exercise Bowel movement: #____/day or #___/week Urination: #_______/day
☐ Coffee #_____Cups/day ☐ Alcohol #_____Drinks/week ☐ Tobacco #_______/day
☐ Vegetarian Have you ever considered or attempted suicide? ☐ Yes ☐ No

Current symptoms: ____
☐ Fatigue ☐ Depression ☐ Mania ☐ Insomnia ☐ Day sweating ☐ Night Sweats
☐ Weight Loss ☐ Weight Gain ☐ Area of numbness ☐ Headaches ☐ Anxiety
☐ muscular weakness ☐ Arthritis ☐ Muscle sprains ☐ Muscle cramps ☐ Spasms

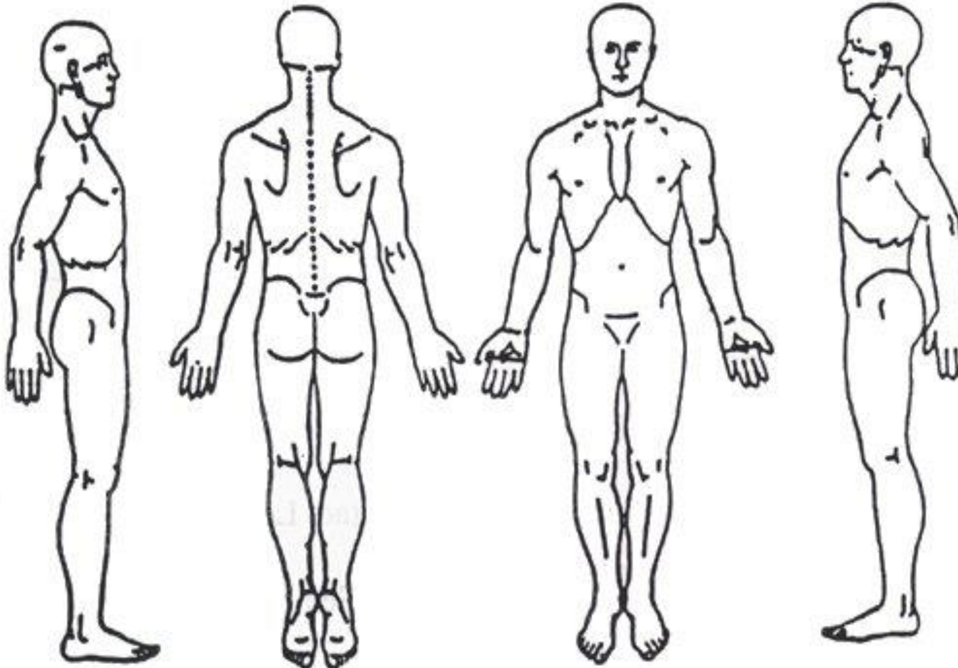
☐ Acid reflex ☐ Abdominal pain/cramps ☐ IBS ☐ Constipation ☐ Diarrhea
☐ Pain on urination ☐ Blood in urine ☐ Waking up to urinate ☐ Frequent urination
☐ High blood pressure ☐ Low blood pressure ☐ Palpitations ☐ Irregular heartbeat ☐ High Cholesterol
☐ Cough ☐ Asthma ☐ Difficulty in breathing Other: ___________________________________

Females: Pregnancy & Gynecology
Are you pregnant? Yes ☐ No ☐ If yes, expected due date ______________
Age at First Menses: ______ Age at Menopause ____ Number of Pregnancies_____
Number of Births:_______ Miscarriages_______ Abortions_______
☐ Birth Control What type?___________ How long? _______
☐ Fertility problems ☐ Irregular vaginal Discharge

Menses: Length of cycle:____days per month Duration of Flow: ____days of bleeding
☐ _Heavy ☐ Light ☐ Clots ☐ Painful Periods ☐ Irregular Periods ☐ Breast Lumps

Date of last Pap Smear ___________________ Date of last Mammogram _______________________

Please circle on the diagram any areas of any type of pain or injury



Please try to describe the type and quality of the pain:
☐ Dull ☐ throbbing ☐ Knife like ☐ Cramping ☐ Moving radiating pain ☐ Fixed area pain ☐ Constant
Aggravating factors: ☐ Sitting ☐ Lifting ☐ Bending forward ☐ other ___________________________
Relieving factors: ☐ cold ☐ heat ☐ rest ☐ exercise ☐ other ___________________________
Intensity: Your Current Pain Level Is: _________________(Scale of 1-10)