SELBY ACUPUNCTURE

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St. Paul, MN 55102
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Patient Health History

Please fill out the form as completely as possible.

Date: _____ Name: _____ Nickname: _____
Date of Birth: _____ Relationship Status: ☐ Married ☐ Partnered ☐ Single ☐ Widowed ☐ Divorced
Address: _____
(street) (apt #)
_____
(city) (state) (zip)
Main Contact Phone: _____ Secondary Phone: _____
Email: _____ May we include you on our email newsletter? ☐ Y ☐ N
Occupation: _____ Employer: _____ Hours/week _____
Emergency Contact: _____
(name) (relationship) (phone)
Primary Physician: _____
(name) (location) (phone)

Please list your major health concerns in order of importance:

Complaint	Since	Severity (scale of 1-10, 10 = severe)	Other treatments received (Dr., DC, DO, DOS)

Is this condition(s) getting progressively worse? ☐ Yes ☐ No ☐ Constant ☐ Comes and Goes
Is this condition(s) interfering with your: ☐ Work ☐ Sleep ☐ Daily Routine ☐ Other (specify) _____
How long has it been since you have felt really good? _____
Do you have a pacemaker or bleeding condition? _____
Do you have any infectious disease? ☐ No ☐ Yes (please identify) _____
Please list all known food or drug allergies _____
Please list all medications (prescription and over the counter) you are currently taking _____
_____
_____

Hospitalizations and Surgeries

Reason	When

Personal History (Please indicate Self (X), Mother (M), Father (F), Sister (S), Brother (B), Grandmother (GM), Grandfather (GF))

	AIDS/HIV		Alcoholism		Anemia		Anxiety
	Arthritis		Asthma/Hay Fever		Back pain		Bursitis
	Cancer		Chronic Pain Condition		Chronic Fatigue		Constipation
	Depression		Diabetes		Diverticulitis/IBS		Emphysema
	Food Allergies/Intolerance		Gastritis/Pancreatitis		Headaches		Heart Disease
	Hepatitis		Hypertension		Hypo/Hyperglycemia		Infertility
	Impotence		Insomnia		Liver/Gallbladder Disease		Lyme Disease
	Migraines		Neck Pain		Respiratory Allergies		Raynaud's Disease
	Seizures		Stroke		Thyroid Imbalance		

Women Only

Age of first menses: _____ Date of last menstrual period: _____ Duration of period: _____
Length of cycle: _____ Color of flow: _____
Blood clots in flow? ☐ Yes ☐ No Cramping? ☐ Yes ☐ No
Are you/could you be pregnant? ☐ Yes ☐ No If so, how far along are you? _____
Pregnancies: _____ # Miscarriages: _____ # Abortions: _____

Do you suffer from:
☐ Cramping (mark as appropriate)
☐ Severe ☐ Moderate ☐ Mild
☐ Before period ☐ After period ☐ During period
☐ Clotting
☐ Bright in color ☐ Dark in color Describe color: _____
☐ Premenstrual Syndrome
☐ Fluid retention ☐ Cravings ☐ Fluctuating emotions ☐ Irritability
☐ Depression ☐ Fatigue ☐ Breast tenderness
Other symptoms:
☐ Bleeding between periods ☐ Endometriosis ☐ Mastitis ☐ Yeast Infection/Vaginitis
☐ Infertility ☐ Ovarian Cysts ☐ Hot flashes ☐ Breast cysts
☐ Bleeding/spotting after menopause

Anything else we should know? _____

How did you hear about us? _____

Signature (or type name) _____ Date _____