

721 Ridge Road webster, NY 14580  
 585-872-5007 www.StokesAcupuncture.com  
**Health History Questionnaire and Registration**



Patient Information	Contact Information
Date _____ Name _____ Address _____ City State Zip _____ Age _____ Birthdate _____ Occupation _____ Company name _____ Primary physician _____ Physician phone number _____ How did you hear about us? _____	Home phone _____ Work phone _____ Other/cell phone _____ Email _____  Another person we may contact if needed: Name _____ Relationship _____ Home phone _____ Work phone _____

Health History	
What are your primary concerns for coming in for treatment? 1- _____ 2 - _____ 3 - _____  How is your sleep? _____  How is your digestion? _____  List medications or vitamin supplements you are taking. _____  List serious illnesses, accidents or surgeries. _____  Check illnesses that have occurred in blood relatives.	Check symptoms you have or have had in the last year: <ul style="list-style-type: none"> <li><input type="checkbox"/> Depression</li> <li><input type="checkbox"/> Difficulty in focusing</li> <li><input type="checkbox"/> Dizziness</li> <li><input type="checkbox"/> Easily startled</li> <li><input type="checkbox"/> Excessive worry</li> <li><input type="checkbox"/> Excessive anger</li> <li><input type="checkbox"/> Excessive fear</li> <li><input type="checkbox"/> Fatigue/tiredness</li> <li><input type="checkbox"/> Headaches</li> <li><input type="checkbox"/> Loss of sleep/poor sleep</li> <li><input type="checkbox"/> Loss or gain of weight</li> <li><input type="checkbox"/> Nervousness/irritability</li> <li><input type="checkbox"/> Overwhelmed by life</li> </ul> Check conditions you have or have had in the past: <ul style="list-style-type: none"> <li><input type="checkbox"/> AIDS</li> <li><input type="checkbox"/> Allergies</li> <li><input type="checkbox"/> Anemia</li> <li><input type="checkbox"/> Arthritis</li> </ul>

___ Diabetes    ___ High blood pressure    ___ Stroke ___ Cancer    ___ Heart disease    ___ Kidney disease	<ul style="list-style-type: none"> <li><input type="checkbox"/> Bleeding disorders</li> <li><input type="checkbox"/> Breast lump</li> <li><input type="checkbox"/> Cancer</li> <li><input type="checkbox"/> Diabetes</li> </ul> <p>How long has it been since you have had a complete medical exam? _____</p>
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**Health History...continued**

<p>Check symptoms you have or have had <b>in the last year:</b></p> <p><b>MUSCLE/JOINT/BONES</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Tremors c Cramps</li> <li><input type="checkbox"/> Swollen joints</li> </ul> <p>Pain, weakness, numbness in:</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Arms</li> <li><input type="checkbox"/> Back or Hips</li> <li><input type="checkbox"/> Legs</li> <li><input type="checkbox"/> Feet</li> <li><input type="checkbox"/> Neck</li> <li><input type="checkbox"/> Hands</li> <li><input type="checkbox"/> Shoulders</li> <li><input type="checkbox"/> Other _____</li> </ul> <p><b>EYES/EAR/NOSE/THROAT/RESPIRATORY</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Asthma/wheezing</li> <li><input type="checkbox"/> Blurred or failing vision</li> <li><input type="checkbox"/> Difficulty breathing</li> <li><input type="checkbox"/> Earache</li> <li><input type="checkbox"/> Enlarged glands</li> <li><input type="checkbox"/> Eye pain</li> <li><input type="checkbox"/> Frequent colds</li> <li><input type="checkbox"/> Hay fever</li> <li><input type="checkbox"/> Hoarseness</li> <li><input type="checkbox"/> Gum trouble</li> <li><input type="checkbox"/> Nose bleeds</li> <li><input type="checkbox"/> Loss of hearing</li> <li><input type="checkbox"/> Persistent cough</li> <li><input type="checkbox"/> Ringing in ears</li> <li><input type="checkbox"/> Sinus problems</li> </ul> <p><b>SKIN</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Boils</li> </ul>	<p><b>CARDIOVASCULAR</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Chest pain</li> <li><input type="checkbox"/> Hardening of arteries</li> <li><input type="checkbox"/> High or low blood pressure</li> <li><input type="checkbox"/> Pain over heart</li> <li><input type="checkbox"/> Poor circulation</li> <li><input type="checkbox"/> Previous heart attack</li> <li><input type="checkbox"/> Rapid/irregular heart beat</li> <li><input type="checkbox"/> Swelling of ankles</li> </ul> <p><b>GASTROINTESTINAL</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Belching, gas or bloating</li> <li><input type="checkbox"/> Colon trouble</li> <li><input type="checkbox"/> Constipation</li> <li><input type="checkbox"/> Diarrhea</li> <li><input type="checkbox"/> Difficulty swallowing</li> <li><input type="checkbox"/> Distention of abdomen</li> <li><input type="checkbox"/> Excessive hunger</li> <li><input type="checkbox"/> Gall bladder trouble</li> <li><input type="checkbox"/> Hemorrhoids (piles)</li> <li><input type="checkbox"/> Indigestion</li> <li><input type="checkbox"/> Nausea</li> <li><input type="checkbox"/> Pain over stomach</li> <li><input type="checkbox"/> Poor appetite</li> <li><input type="checkbox"/> Vomiting</li> </ul> <p><b>FOR MEN ONLY</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Erection difficulties</li> <li><input type="checkbox"/> Penis discharge</li> <li><input type="checkbox"/> Prostate trouble</li> </ul>
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- Bruise easily
- Dry skin
- Itching/rash
- Sensitive skin
- Sore won't heal
- Sweats

**FOR WOMEN ONLY**

- Bleeding between periods
- Clots in menses
- Excessive menstrual flow
- Extreme menstrual pain
- Irregular cycle
- Menopausal symptoms
- PMS
- Previous miscarriage
- Previous abortion
- Scanty menstrual flow

**GENITO/URINARY**

- Blood/pus in urine
- Frequent urination
- Inability to control urine
- Kidney infection/stones
- Lowered libido

Could you be pregnant? \_\_\_\_\_

Date of last PAP: \_\_\_\_\_

**Signature**

The information on this form is correct to the best of my knowledge.

Signature \_\_\_\_\_ Date \_\_\_\_\_