

# McBride Healing Community Acupuncture Health History

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Name:		Sex:	Date of Birth:	
Address:		City:	State:	Zip:
Primary Phone #:	Other Phone #:	Home	Cell	Work
Email:				
Height:	Weight:	Emergency Contact Name & Phone #:		
Occupation:		Employer:		
Primary Physician:		Physician's Phone #:		
Where or from whom did you learn about McBride Healing?		Have you been treated by Acupuncture before? <input type="checkbox"/> No <input type="checkbox"/> Yes    when? ____/____/____		

## HEALTH HISTORY

What is your main area of concern?

How long has it bothered you?

How did it start?

What makes it worse?

What makes it better?

How severe are your symptoms today on a scale from 0 - 10? (place and **X** on the line)

**No Symptoms**   0   ←—————|—————→   **10 Worst Ever**

Do you have any blood disorders? (ie. Hepatitis, HIV/AIDS, Clotting Disorders, etc.)

Are you allergic to anything? (medications, foods, environmental)

## MEDICATIONS

Please note what medications, herbs, or supplements that you take regularly.

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## SURGERIES & TRAUMAS

Please note what happened and when it occurred (Physical & Emotional).

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### FOR WOMEN ONLY

#### MENSES

Are you pregnant? \_\_\_\_\_

Age of first menses: \_\_\_\_\_

Length of full cycle: \_\_\_\_\_ (ie 28 days)

Length of menses: \_\_\_\_\_ (ie 5 days)

Last menses start date: \_\_\_\_/\_\_\_\_

# of pregnancies: \_\_\_\_\_

# of births: \_\_\_\_\_ premature: \_\_\_\_\_

# of abortions/miscarriages: \_\_\_\_\_

- Heavy periods
- Light periods
- Painful periods
- Irregular periods
- PMS - (Changes in body/psyche prior to menstruation)
- Birth control pill

#### MENOPAUSE

Age of last menses: \_\_\_\_\_

Year changes began: \_\_\_\_\_

Hot flashes \_\_\_\_\_ x/day

Night sweats \_\_\_\_\_ x/week

- Vaginal dryness
- Loss of sex drive