

# CLIENT HEALTH HISTORY



Acupuncture Center of Ann Arbor  
 180 Little Lake Drive • Suite 4, Ann Arbor, MI 48103  
 (734) 222-8210 • www.acupuncturecenteraa.com

Name \_\_\_\_\_ Date: \_\_\_\_\_  
 Phone - Home: \_\_\_\_\_ Cell: \_\_\_\_\_ Work: \_\_\_\_\_  
 Date of Birth: \_\_\_\_\_ Email address: \_\_\_\_\_  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Occupation: \_\_\_\_\_ Referred by: \_\_\_\_\_  
 Currently under care of: \_\_\_\_\_ For : \_\_\_\_\_

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| <p><b>PLEASE PRINT CLEARLY</b></p> <p>Sex: _____ Age: _____ Ht: _____<br/>                 Weight: _____ B/P: _____ / _____<br/>                 Birthdate: _____ / _____ / _____<br/>                 Birthplace: _____</p> <p><b>Marital History</b><br/> <input type="checkbox"/> Married _____ yrs<br/> <input type="checkbox"/> Divorced _____ yrs<br/> <input type="checkbox"/> Single _____<br/>                 Children? _____ Ages? _____<br/>                 Number of pregnancies: _____<br/>                 Deliveries: _____<br/>                 Miscarriages: _____<br/>                 Complications: _____<br/>                 Abortions: _____</p> <p><b>Childhood diseases:</b> measles, mumps, chicken pox, diphtheria, whooping cough, tonsillitis, ear infections, other: _____</p> <p>_____</p> <p>_____</p> <p><b>Childhood vaccinations:</b></p> <p>_____</p> <p>_____</p> <p>_____</p> <p><b>Operations - what and when:</b></p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> | <p><b>Accidents: what and when:</b></p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p><b>Family history:</b> Please encircle conditions that your parents or siblings have had: Diabetes, Cancer, Heart Disease, Asthma, Kidney Disease, Stomach Disorder, Gallbladder Disease, Arthritis, Other: _____</p> <p>_____</p> <p><b>Habits:</b> Coffee _____ Tea _____<br/>                 Sugar _____ Chocolate _____<br/>                 Cigarettes _____ Laxatives _____<br/>                 Alcohol _____<br/>                 Recreational drugs _____<br/>                 Work _____ hrs/week<br/>                 Sleep _____ hrs<br/>                 Exercise _____ times/wk</p> <p><b>Complaints that brought you here:</b></p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p><b>How long since well:</b></p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> | <p><b>What would you like to do that your current health problems are preventing you from doing?</b></p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p><b>List all nutritional supplements including vitamins, minerals, brand names, amounts taken, etc.:</b></p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p><b>List all prescription drugs you are currently taking and dosage:</b></p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> |
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## NUTRITIONAL DEFICIENCY SIGNS AND SYMPTOMS

\*\*Encircle all that apply to you\*

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| <p><b><u>Headaches:</u></b><br/> Migraines<br/> Frontal<br/> Back of neck<br/> Sinus<br/> Temples<br/> How often? _____<br/> _____</p> <p><b><u>Sinus problems:</u></b><br/> Nose: dry, stuffy, congested, runny<br/> Mouth breather<br/> Nosebleeds<br/> Frequent sinusitis or sinus infections<br/> Sinus headaches</p> <p><b><u>Ear problems:</u></b><br/> Frequent ear aches or infections<br/> Fluid in ears<br/> Loss of hearing<br/> Ringing in the ears (Tinnitus)</p> <p><b><u>Eye Problems:</u></b><br/> Vision getting worse<br/> Floaters<br/> Bloodshot<br/> Feeling of sand in eyes<br/> Eye pain<br/> Get headaches when reading<br/> Glaucoma<br/> Cataracts<br/> Macular degeneration<br/> Other _____<br/> _____</p> <p><b><u>Mouth and throat problems:</u></b><br/> Sores on tongue<br/> Sores in mouth<br/> Speech problems<br/> Frequent sore or irritated throat<br/> Hard lumps under jawbone (marbles)<br/> Swollen glands</p> <p><b><u>Dental problems:</u></b><br/> Silver amalgam fillings?<br/> How many? _____</p> | <p>Root canals? _____<br/> How many? _____<br/> Frequent abscesses<br/> Titanium implants<br/> Gum surgery<br/> Gum problems _____</p> <p><b><u>Skin problems:</u></b><br/> Skin is: dry / moist / oily<br/> Itching: _____ where? _____<br/> Acne / cystic acne<br/> Eczema<br/> Psoriasis<br/> Rosacea<br/> Allergic to bee stings, bug bites<br/> Allergic to poison oak/ivy<br/> Frequent hives or rashes: _____<br/> Where? _____<br/> _____</p> <p>Frequent skin/nail fungal infections<br/> Herpes: where? _____</p> <p><b><u>Cardiovascular system:</u></b><br/> Irregular or skipped heartbeats<br/> Heart palpitations<br/> Mitral valve prolapse<br/> Poor circulation<br/> High cholesterol<br/> Total cholesterol _____<br/> High triglycerides<br/> Total triglycerides _____<br/> Chest pain, angina<br/> Congestive heart failure<br/> Heart attacks - how many? _____<br/> Chelation therapy? _____<br/> If so, when? _____</p> <p><b><u>Lung problems:</u></b><br/> Frequent coughing<br/> Mucous<br/> Color of mucous? _____<br/> Shortness of breath<br/> Asthma<br/> Wheezing<br/> Difficulty breathing deeply<br/> Frequent lung infections<br/> Bronchitis<br/> Emphysema</p> | <p><b><u>Liver problems:</u></b><br/> Can't tolerate vitamins<br/> Can't tolerate alcohol or drugs<br/> Coated tongue<br/> Nausea after high fat meals<br/> Jaundice<br/> Hepatitis? _____<br/> What kind? _____</p> <p><b><u>Gallbladder problems:</u></b><br/> Intolerance of fatty foods<br/> Intolerance of spicy foods<br/> Frequent sour taste in mouth<br/> Frequent regurgitation of food<br/> Can't lay down after eating or else<br/> regurgitate<br/> Burping, pain or nausea after meals<br/> Pain or discomfort under right rib<br/> cage after meals<br/> Gallbladder disease/surgery</p> <p><b><u>Stomach problems:</u></b><br/> Stomach pain _____ Where? _____<br/> _____<br/> _____<br/> Frequent bloating? _____<br/> In stomach or abdomen? _____<br/> _____<br/> Frequent nausea? _____<br/> When? _____<br/> _____<br/> Burning relieved by eating<br/> Nausea relieved by eating<br/> Frequent vomiting? _____<br/> When? _____<br/> _____<br/> Esophageal reflux (GERD)<br/> Do you take antacids? _____<br/> Which ones? _____<br/> _____<br/> Ulcers<br/> Gastritis (NOT flatulence)<br/> Helicobacter pylori<br/> Hiatal Hernia</p> |
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**Urinary Tract problems:**

Bladder infections  
Pain when voiding  
Burning urination (cystitis)  
Frequent urination or urgency  
Loss of control or incontinence  
Pass small amounts at each voiding  
Bedwetting (enuresis)  
Frequent urination at night; \_\_\_\_\_  
how often \_\_\_\_\_  
History of kidney stones/surgery

**Colon problems**

**(Large/small intestines):**

Malabsorption  
Candidiasis  
Other fungal infections: \_\_\_\_\_  
Where? \_\_\_\_\_

Diarrhea or loose stools  
Constipation  
Hard, painful stools  
Constipation alternating with diarrhea  
Infrequent bowel movements  
# of daily bowel movements \_\_\_\_\_

Laxatives: how often? \_\_\_\_\_  
Enemas: how often? \_\_\_\_\_  
Colonics: how often? \_\_\_\_\_

Hemorrhoids  
Abdominal pain (circle where if yes):  
Lower right quadrant \_\_\_\_\_  
Lower left quadrant \_\_\_\_\_  
Any other region? \_\_\_\_\_

Mucous in the stool  
Blood in the stool  
Rectal pain  
Rectal bleeding  
Rectal itch \_\_\_\_\_  
When? (day / night / random)

Diagnosed with:  
Irritable Bowel Syndrome  
Crohn's Disease  
Colitis  
Diverticulitis  
Diverticulosis  
Other \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Sugar metabolism problems:**

Hypoglycemia  
Diarrhea or loose stools  
Seizures  
Childhood asthma  
Adult asthma  
Insomnia  
Nightmares  
Mood swings  
Irritable, angry or violent behavior  
Hyperactivity, attention deficit (ADD)  
Manic depression  
Bipolar Disorder  
Schizophrenia  
Panic attacks  
Anxiety (sigh a lot)  
Glucosuria (sugar in urine)  
Diabetes I \_\_\_\_\_ Onset? \_\_\_\_\_  
Diabetes II \_\_\_\_\_ Onset? \_\_\_\_\_

**Calcium metabolism problems:**

Leg cramps  
Restless legs at night  
Nocturnal cramp in toes, legs, etc.  
Night cough  
Joint pain or stiffness  
Low back pain  
Weak joints or ligaments  
Fallen arches  
Bone spurs  
Deep bone pain  
Loose teeth  
Poor fitting dentures  
Arthritis  
Rheumatoid arthritis  
Osteoarthritis  
Osteoporosis  
Gout  
Ankylosing spondylitis

**Female problems:**

Vaginal discharge  
Painful intercourse  
Low libido  
Hair growth on face  
Painful or tender breasts, worse  
at menses  
Fibrocystic breast disease  
Uterine fibroids  
Ovarian pain  
Ovarian cysts  
Endometriosis  
Miscarriages? \_\_\_\_\_  
How many? \_\_\_\_\_  
Infertile  
Taking fertility drugs  
PMS symptoms: cramps / irritable  
depressed / moody  
Acne, worse at menses  
Headaches, worse at menses  
Vomiting during menses  
Menses: irregular / excessive  
too frequent / infrequent / scanty  
amenorrhea (no menstrual periods)  
Surgical menopause: total / partial  
Hot flashes, day or night  
Cancer : ovarian / cervical  
uterine / breast  
Other: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Male problems:**

Prostatic hypertrophy  
Urination difficult or dribbling  
Frequent urination  
Night urination  
Feeling of incomplete bowel  
evacuation  
Painful intercourse  
Impotence  
Low libido  
Pain in groin  
Pain down front of legs  
Sore genitals  
Discharge from genitals  
Prostate cancer



**Conditions that respond to protease:**

Anxious, sign a lot; take tranquilizers  
Cold hands and feet  
Water retention (edema): hands, ankles, fluid in ears  
Immune system problems:  
AIDS  
cancer  
bacterial or viral infections - describe:  
\_\_\_\_\_

Kidney problems: kidney disease, nephritis

Calcium and bone problems:

arthritis  
osteoporosis  
disc problems  
gout  
bone spurs

Blood clots

Acute pancreatitis

Soft tissue trauma - accidental or surgical

**Conditions that respond to amylase:**

Frequent hives or rashes

Eczema

Psoriasis

Herpes - any kind including canker sores, Herpes I or II, shingles, chicken pox, etc.

Allergies to bee stings or bug bites

Allergies to poison oak, ivy

Abscesses anywhere such as teeth

**Conditions that respond to cellulase:**

Malabsorption of nutrients

Gas, bloating

Acute food allergies

Fungal/yeast infections

Facial pain or neuralgia

Facial paralysis (Bell's Palsy)

**Conditions that respond to lipase:**

Low stomach acid (hypochlorohydrria)

Gallbladder symptoms:

Frequent sour taste in mouth,  
Burping and/or nausea after meals,  
Intolerance of fatty or spicy foods,  
gallstones, gallbladder surgery

Hidden (recurrent) viruses

High cholesterol \_\_\_\_\_

High triglycerides \_\_\_\_\_

Difficulty losing weight

High blood pressure

Taking medication

Cardiovascular problems

Varicose veins

Diabetes I or II, taking insulin or oral anti-diabetic drug

Dizziness when moving or changing positions

**Conditions that respond to disaccharidases: lactose (dairy); sucrose (cane sugar); and maltose (grain sugar)**

**1. Physical symptoms:**

Diarrhea

Abdominal cramps

Body odor

Constipation (sometimes from sucrose intolerance)

Gluten intolerance (Celiac disease)

Lung problems: asthma, bronchitis

Environmental illness:

bothered by perfumes, chemicals, air pollutants, smoke, etc.

Spaciness

Dizziness, especially when

bending over

Seizure disorders

**2. Mental/emotional symptoms:**

Insomnia

Nightmares

Depression

Mood swings

Irritable or angry

Aggressive or violent behavior

Panic attacks

Manic depressive

Bipolar Disorder

Attention Deficit Hyperactivity Disorder (ADD or ADHD)

**Please list all foods that you know cause allergies (do not list blood allergy test results here; instead attach a copy. List only the foods that you are sure cause allergic reactions:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Encircle your environmental allergies, including chemicals, plants, and animals:**

Pollens, molds, smoke, smog, auto fumes, perfumes, weeds, grasses, flowers, cats, dogs, horses, paint, dust, detergents, new carpet, mobile home syndrome (formaldehyde)  
others:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## Physical Symptoms Survey

Please describe your problem and tell how it began \_\_\_\_\_

When did you first notice this problem? \_\_\_\_\_ Have you experienced this problem before? \_\_\_\_\_  
Is the problem of a mild, medium or severe nature? \_\_\_\_\_ Does it keep you from your daily activities? \_\_\_\_\_

Circle the words that best describe your symptoms: dull, aching, sharp tingling, burning itching, numb, other \_\_\_\_\_

Is this a constant problem or does it come and go? \_\_\_\_\_ Is it worse at a specific time of day? \_\_\_\_\_

Has the problem become worse, stayed the same or improved since the onset? \_\_\_\_\_

Does it extend or radiate into other areas? \_\_\_\_\_ Does anything make the symptoms better? \_\_\_\_\_

Have you seen another health care professional for this problem? \_\_\_\_\_

If so, what was the diagnosis and treatment? \_\_\_\_\_

Please shade in the areas of difficulty, pain or injury.



