BALBOA PARK
HOLISTIC WELLNESS CENTER

2310 6th Avenue San Diego, CA 92101 (619)772-4002

Name_____ Date of injury/illness_____

Address _____ City _____State _____Zip_____

Home Phone _____Work Phone _____E-mail _____

Date of birth _____ Driver's License # _____Preferred language_____

Gender at birth _____ Preferred pronouns _____

Employer/school _____Occupation_____

Emergency Contact_____Phone_____Relationship_____

Referred By_____

Have you had acupuncture before? _____yes _____no

Is your condition a result of a work injury? _____ Motor vehicle accident? _____

History of current complaint

Reason for today's visit_____

_____

How long have you had these symptoms? _____

What other treatment have you had for this condition? _____

_____

_____

What seems to make it better? _____

What seems to make it worse? _____

Please list other conditions for which you are under the care of a physician: _____

_____

What medications are you taking? (Please include over the counter medications, herbs, cannabis, mushrooms, and vitamins as well as prescription medications) _____

_____

_____

_____

Do you know what your blood pressure usually is? _____yes _____no if yes: _____/_____

Medical History

Please check any of the following conditions you currently have or have previously had:

Now	Previous		Now	Previous		Now	Previous	
___	___	Alcoholism	___	___	Diabetes	___	___	Pacemaker
___	___	Allergies	___	___	Epilepsy	___	___	Pneumonia
to what _____			___	___	Fibromyalgia	___	___	Polio
_____			___	___	Glaucoma	___	___	Rheumatic Fever
___	___	Anemia	___	___	Gout	___	___	Scarlet Fever
___	___	Appendicitis	___	___	Heart Disease	___	___	Seizures
___	___	Arteriosclerosis	___	___	Hepatitis	___	___	Stroke
___	___	Asthma	___	___	Herpes	___	___	Thyroid Disorders
___	___	Cancer	___	___	Hypertension	___	___	Tuberculosis
type_____			___	___	HIV/AIDS	___	___	Ulcers
_____			___	___	History of Abuse	___	___	Venereal Disease
_____			___	___	Measles	___	___	Other (Please
___	___	Chicken Pox	___	___	Mental Illness	explain)_____		
___	___	Chronic Fatigue	___	___	Multiple Sclerosis	_____		
___	___	Depression	___	___	Mumps			

Please list dates and types of all surgeries you have had:

_____

_____

_____

Please list any major traumas and accidents you have had:

_____

_____

_____

Family Medical History

Please check any of the following that someone in your immediate family (sisters, brothers, parents, grandparents, aunts, uncles) has had, and which family member was affected:

Allergies	_____	Cancer	_____
Asthma	_____	Diabetes	_____
Alcoholism	_____	Heart Disease	_____

High Blood Pressure _____ Seizures _____

Lifestyle Information

Appetite ____low ____high ____moderate

Are you vegetarian? ____yes ____no

Do you have cravings for specific foods? ____yes ____no

If yes, what do you crave? _____

How many glasses of water do you drink in a typical day? _____

Regular Exercise Type_____ How often_____

Current Symptoms (Check all which apply)

__Hard to fall asleep
__Hard to stay asleep
__Dream disturbed sleep
__Wake earlier than desired
__Diarrhea
__Constipation
__Bloating
__Bad Breath
__Blood in stools
__Hard to pass stools
__Hemorrhoids
__Abdominal pain/cramps
__Recent changes to bowels
__Nausea
__Vomiting
__Acid reflux
__Frequent urination
__Difficult urination
__Blood in the urine
__Stones in the urine
__Pain with urination
__Cloudy urine
__Unable to hold urine
__Recent changes to urination
__Decreased libido
__Anxiety
__Depression
__Easily stressed
__Brain fog/memory issues
__History of abuse
__Considered suicide
__Self-harm
__Seeing a therapist
__Headaches
__Migraines
__Vertigo/dizziness
__Ear ringing
__Seizures
__Fainting
__History of concussion
__High blood pressure
__Low blood pressure
__Palpitations
__Rapid heart rate
__Irregular heart rate
__On blood thinner
__Bruise/bleed easily
__Shortness of breath
__Wheezing
__Chronic dry cough
__Chronic wet cough
__Coughing blood
__Cold hands/feet
__Poor circulation
__Varicose veins
__Fatigue/low energy
__Tend to run cold
__Tend to run warm
__Unusual sweating
__Night sweats
__Hot flashes
__Sinus problems
__Muscle weakness
__Muscle spasms
__Joint pain
__Reduced range of motion
__TMJ

__Dental problems
__Itching
__Recent changes to skin/hair

For People Born With a Uterus

Age at first period_____ Age at menopause _____

# of days between periods_____ # of days periods last _____ # of pregnancies_____

# of live births _____ date of last PAP _____

Check all which apply:

__Painful periods
__Clotted periods
__Very light periods
__Very heavy periods
__Irregular periods
__PMS
__On birth control
__Vaginal discharge
__Vaginal odor
__Hysterectomy
__Mood swings around period
__Pelvic pain
__Breast tenderness
__Breast fibroids
__Abnormal mammogram
__Abnormal PAP history
__On hormone replacement

For people born without a uterus (check all which apply)

__Hesitant urination
__Impotence
__Lack of libido
__Premature ejaculation
__Elevated PSA
__Increased breast size
__Low energy
__Testosterone supplementing

Is there anything else you feel we should know about you? _____

_____

_____

_____

_____

_____

Thank you for taking the time to help us to help you!