



Eagle Rock Community Acupuncture
2042 Colorado Boulevard • Los Angeles, CA 90041
323-255-2700 • www.ercaclinic.com

Health History Questionnaire

PATIENT INFORMATION	CONTACT INFORMATION
Name: _____	Home Phone: _____
Address: _____	Work Phone: _____
City, State, Zip: _____	Cell Phone: _____
Age: _____ DOB: _____	Email: _____
Occupation: _____	Emergency Contact: _____
Company Name: _____	Relationship: _____
Primary Physician: _____	Home Phone: _____
How did you hear about us? _____	Work Phone: _____
	Cell Phone: _____

GENERAL INFORMATION *(PLEASE CHECK THAT WHICH APPLIES)*

EXERCISE

- None
- Moderate
- Daily
- Heavy

WORK ACTIVITY

- Sitting
- Standing
- Light Labor
- Heavy Labor

HABITS

- Smoking
- Alcohol
- Coffee/Caffeine Drinks
- High Stress Level

Packs/Day _____

Drinks/Week _____

Cups/Day _____

Reason _____

HEALTH HISTORY

In order of importance, please list your primary concerns for coming in for treatment?

1. _____
2. _____
3. _____

(for office use only)

Please check the symptoms you have or have had in the last year:

- Depression
- Difficulty focusing
- Dizziness
- Easily Startled
- Excessive worry
- Excessive anger
- Excessive fear
- Fatigue/Tiredness
- Headaches
- Loss of sleep/poor sleep
- Loss or gain of weight
- Nervousness/Irritability
- Overwhelmed by life

HEALTH HISTORY...CONTINUED

List all medications/herbs/vitamins/supplements you are currently taking:

List major injuries/surgeries/illness:

Please check symptoms you have or have had in the last year:

MUSCLE/JOINT/BONES

- Tremors or Cramps
- Swollen joints

Pain, weakness or numbness in:

- Arms
- Shoulders
- Neck
- Back
- Legs / Hips
- Hands, Fingers
- Feet, Toes
- Other _____

EYES/EAR/NOSE/THROAT/RESPIRATORY

- Arms/Asthma/Wheezing
- Blurred or failing vision
- Difficulty breathing
- Earache
- Enlarged glands
- Eye pain
- Frequent colds
- Hay fever
- Hoarseness/Loss of voice
- Gum problems
- Nose bleeds
- Loss of hearing
- Persistent cough
- Ringing in ears/Tinnitus
- Sinus problems

SKIN

- Boils
- Bruise easily
- Dry or Sensitive skin
- Sweating
- Itching/Rash
- Sensitive skin
- Non-healing sores
- Acne

Please check conditions you have or have had in the past:

- AIDS/HIV
- Allergies
- Anemia
- Arthritis
- Bleeding Disorders
- Breast Lumps
- Cancer
- Diabetes

Please check the illness that pertain to blood relatives:

- Arthritis
- Blood Disorder
- Cancer
- Diabetes
- Heart Disease
- High Blood Pressure
- Kidney Disease
- Seizures
- Stroke
- Thyroid Disease

When was your last complete medical exam? _____

CARDIOVASCULAR

- Chest pain
- Hardening of arteries
- High or low blood pressure
- Pain over heart
- Poor circulation
- Previous heart attack
- Rapid/Irregular heart beat
- Swelling of ankles

GASTROINTESTINAL

- Belching, Gas or Bloating
- Colon problems
- Constipation
- Diarrhea
- Difficulty swallowing
- Distention of abdomen/Bloating
- Excessive hunger
- Gallbladder problems
- Hemorrhoids (piles)
- Indigestion
- Nausea
- Pain over stomach
- Poor appetite
- Vomiting

GENITO/URINARY

- Blood/Pus in urine (Urinary Tract Infections)
- Frequent urination
- Inability to control urine
- Kidney infection/Kidney stones
- Lowered libido

HEALTH HISTORY...CONTINUED

WOMEN ONLY

Are you pregnant? Yes No

Age of first period? _____

Date of last period? _____

Age of menopause? _____

Color of menstrual flow:

Light Red Bright Red Dark Red
 Purple Brown Black

- Bleeding between periods
- Excessive menstrual flow
- Scanty menstrual flow
- Extreme menstrual pain
- Irregular menstrual cycle
- Clotting in menstrual blood
- PMS
- Previous Miscarriage
- STD

MEN ONLY

- Erectile Dysfunction
- Premature Ejaculation
- Discharge from penis
- Prostate problems
- Infertility
- STD
- Other _____

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

Signature: _____

Date: _____

Please read the following information carefully, and ask your practitioner if there is anything that you do not understand.

Acupuncture is a form of treatment whereby fine, specialized, sterile needles are inserted through the skin at specific points on the body. Acupuncture is very safe. Adverse effects are rare.

What you need to know:

- Drowsiness may occur in a small number of patients.
- Minor bleeding and/or bruising may occur in less than 1% of treatments.
- Symptoms can worsen after a treatment, (in less than 3% of patients). If this occurs in your case, please contact your Acupuncturist promptly.
- Faintness and fainting can occur, particularly in the first treatment. If you feel faint at any time, tell your practitioner immediately.

Additionally, if there are particular risks that apply in your case, your Acupuncturist will discuss these with you.

Apart from routine medical details that will be discussed during your intake, it is important you let your Acupuncturist know:

- If you have ever experienced fainting or are sensitive or nervous about needles.
- If you have a pacemaker or any other electrical implants.
- If you have a bleeding disorder.
- If you are taking any drugs, particularly anti-coagulants (blood thinners).
- If you have damaged heart valves or have any other particular risk of infection.

Eagle Rock Community Acupuncture Clinic uses single-use, sterile disposable acupuncture needles.

Other therapies that may be used in your treatment include:

Cupping – the application of specialized cups placed on the skin with a vacuum seal created by heat or pump. This therapy is designed to stimulate the flow of blood and Qi in the superficial muscle layers. Any bruising or redness that occurs will dissipate within a few days.

Gua Sha – a technique whereby a specialized tool is used to gently scrape or rub the skin over a problem area. Slight redness of skin will occur and dissipates quickly.

Massage – the manipulation of muscle tissue to relieve pain, tension and inflammation.

Electro-acupuncture – the use of a very mild electrical current with acupuncture needles.

Infrared Heat Therapy – the application of heat absorbed deep into the cells of the body to relieve muscular pain and inflammation

Statement of Consent

I confirm that I have read and understand the above information, and that I consent to receive acupuncture treatment. I understand that I may refuse treatment or an element of treatment at any time. I acknowledge no guarantees have been made with regard to the outcome of my treatment(s). I release the practitioners of Eagle Rock Community Acupuncture, Inc. from all liability that may occur in connection with the procedures mentioned above.

Signature: _____ Date: _____

Print Name: _____