WHITE CYPRESS
NATURAL HEALTH LLC

HEALTH HISTORY/INTAKE FORM

PERSONAL INFORMATION:
Name:_____
Date of Birth:_____
Address:_____
_____
Phone:_____
Email:_____
How were you referred?:_____

EMERGENCY CONTACT:
Emergency Contact:_____
Relationship:_____
Phone:_____

HEALTH HISTORY:
List and explain, including dates and treatments.
Surgeries:_____
_____
Accidents:_____
_____
Major Illness:_____
_____

CURRENT HEALTH STATUS:
Primary Concern:_____
_____
How long has it persisted?:_____
_____
Treatment received?:_____
_____
Secondary Concerns:_____
_____

DAILY ACTIVITY:
Work:_____
Recreation:_____
_____

PLEASE MARK PAST OR PRESENT HEALTH CONCERNS:

NERVOUS SYSTEM:
- ○ Head Injury/Concussion
- ○ Numbness/Tingling
- ○ Loss of Memory/Confusion
- ○ Pinched Nerve/Shooting Pain
- ○ Chronic Pain

MUSKULOSKELETAL:
- ○ Bone and Joint Disease
- ○ Tendonitis/Bursitis
- ○ Arthritis/Gout
- ○ Sprains/Strains
- ○ Low Back/Hip/Leg Pain
- ○ Neck/Shoulder/Arm Pain
- ○ Spasms/Cramps
- ○ Jaw Pain/TMJ Dysfunction
- ○ Osteoporosis
- ○ Scoliosis/Spinal Problems
- ○ Broken Bones
- ○ Stiff or Painful Joints
- ○ Weak or Sore Muscles

SKIN:
- ○ Rashes/Herpes/Cold Sores
- ○ Athlete's Foot/Warts
- ○ Ringworm/Infectious Skin Conditions
- ○ Eczema
- ○ Psoriasis

DIGESTIVE/ELIMINATION:
- ○ Kidney/Bladder Ailment
- ○ Constipation/Diarrhea
- ○ Irritable Bowel Syndrome

Home:_____

Are there any activities that affect your condition?
Explain:_____
_____
How do you reduce stress?:_____
_____
Do you smoke/drink?:_____
_____

MEDICATIONS:
Current Medication:_____
_____
_____
Vitamins/Supplements:_____
_____

- I have listed all my known medical conditions and physical limitations and will inform the acupuncturist in writing of any change in my physical/mental/emotional health. I understand my acupuncturist must be aware of any and all existing conditions that I have in order to effectively and safely treat me. I am responsible for consulting a qualified primary healthcare provider for any ailment I may have. I understand that I am ultimately responsible for my acupuncture bill.

- We believe your time is valuable, and so is ours. This is why we require you to give 24 hours' notice to cancel an appointment.

- If you call the day of to cancel an appointment or you no show, you will be subject to a cancellation fee. Cancellations are the responsibility of the client and are not covered by insurance. We appreciate your understanding on this matter and look forward to providing you with a high quality of care.

ALLERGIES:
- Respiratory: Scents/Pollen
- Skin Detergents/Oils/Lotion
- Foods/Nuts/Fish

CIRCULATORY:
- Heart Disease/Condition
- Phlebitis/Varicose Veins
- Blood Clots
- High/Low Blood Pressure
- Lymph Edema
- Thrombosis/Embolism

RESPIRATORY:
- Shortness of Breath
- Emphysema
- Asthma
- Sinus Problems

REPRODUCTIVE:
- Pregnancy: Weeks_____
- Hysterectomy
- Prostate Problems

GENERAL:
- Cancer/Tumors Benign/Malignant
- Diabetes Type I/Type II
- Chronic Fatigue
- Sleep Disorders
- Migraine/Headaches
- Anxiety/Stress Syndrome
- Depression
- PTSD
- Infections
- Fever/Cold/Flu
- Drug/Alcohol
- Caffeine
- Communicable Diseases/Viruses
- Fungal Infections

OTHER? Please explain:_____
_____
_____

Print Name:_____
Signature:_____ Date:_____