

Patient Health History

Name: _____ Date: _____
(First) (Middle) (Last)

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Email: _____ Occupation: _____

Date of Birth: _____ Gender: _____ Marital Status: _____

Emergency Contact: _____ Telephone: _____ Relationship: _____

Whom may we thank for referring you to us? _____

Successful health care is only possible when the practitioner has a thorough understanding of the patient physically, mentally, and emotionally. Please Complete the following questionnaire as thoroughly as possible.

Are you currently receiving health care? [Yes] [No]

If yes, where and from whom? _____

If no, when and where did you last receive health care? _____

For what reason? _____

Please identify below the health concerns that have brought you to the clinic:

Condition	Past Treatment
1 _____	_____
2 _____	_____
3 _____	_____

Primary Health Concern:

When condition began: _____ Have you had this in the past? [Yes] [No]

Is your condition: [] Getting worse [] Staying Constant [] Coming & Going

What makes it better? _____

What makes it worse? _____

What diagnosis have you been given? _____

What kinds of treatment have you tried? _____

Secondary Health Concern:

When condition began: _____ Have you had this in the past? [Yes] [No]

Is your condition: [] Getting worse [] Staying Constant [] Coming & Going

What makes it better? _____

What makes it worse? _____

What diagnosis have you been given? _____

What kinds of treatment have you tried? _____

Height: _____ Weight: _____ Blood Pressure: _____ / _____

Is today's visit due to Motor Vehicle Collision? [Yes] [No] When? _____

Have you ever had Acupuncture before? [Yes] [No]
 Do you have any chronic infectious disease? [Yes] [No]
 If yes, please explain: _____
 Are you suffering from any chronic illnesses? [Yes] [No]
 If yes, please explain: _____

Significant diseases, injuries, hospitalizations, surgeries, X-Rays/CAT scans/MRI's/ NMR's/etc

Reason	When	Results (if applicable)

Please list any prescription medications, over-the-counter medications, vitamins, or supplements that you are currently taking and give your dosage:

Medication/Vitamin/Supplement	Dosage	Frequency	Reason

Please list any foods, drugs, substances, or medications you are hypersensitive or allergic to

Immunizations (please circle any that you have had):
 Polio Tetanus Measles/Mumps/Rubella Pertussis Diphtheria Hepatitis B Influenza
 Others: _____

Family History	Mother	Father	Brother(s)	Sister(s)
Age [if living]				
Health [G=good, P=poor]				
Age at death [if deceased]				
Cause of death				
Family Illnesses	Mother	Father	Brother(s)	Sister(s)
Allergies				
Cancer				
Diabetes				
Heart Disease				
High Blood Pressure				
Kidney Disease				
Stroke				
Mental Illness				

Emotional – please circle any that you experience currently

Mood Swings Depression Anxiety Mental Tension Anger Easily Irritability
Poor Memory Easily Stressed Mental Fogginess Intrusive Thoughts Abuse Survivor
Considered/Attempted Suicide How long ago? _____ Seeing a Therapist [Yes] [No]
Stress ____/10 Source of Stress? _____
Significant Past Traumas/Emotional State(s) _____

Energy and Immunity – please circle any that you experience currently

Fatigue Slow Wound Healing Chronic Infections Chronic Fatigue Syndrome
Catch Colds Easily Suppressed Immune System Use Energy Drinks [Yes] [No]
Best Time of Day _____ Worst _____ Energy Level ____/10 Other: _____

Head, Eye, Ear, Nose & Throat - please circle any that you experience currently

Glasses Eye Strain Eye Pain Red / Itchy Eyes See Floating Black Spots Night Blindness
Ear Ringing Poor Hearing Ear Aches Headaches / Migraines Concussions Mouth Sores
Swollen Glands Sinus Problems Frequent Sore Throat TMJ/Jaw Problems Dry Mouth
Teeth Problems Gum Problems Hay Fever/Allergies Other _____

Respiratory - please circle any that you experience currently

Pneumonia Frequent Common Colds Difficulty Breathing Persistent Cough
Asthma Bronchitis Difficulty Breathing When Lying Down Other: _____

Cardiovascular - please circle any that you experience currently

Chest Pain Heart Disease High Blood Pressure Low Blood Pressure Palpitations
Irregular Heartbeat Blood Clots Pacemaker Deep Vein Thrombosis Fainting
Are you taking Coumadin/Warfarin? [Yes] [No] Other _____

Gastrointestinal - please circle any that you experience currently

Nausea/Vomiting Epigastric Pain Abdominal Pain Heartburn Gallbladder Disease
Liver Disease Hemorrhoids Gas/Bloating Low Appetite Large Appetite Bad Breath
Fatigue After Eating Laxative Use Anal Fissures Other: _____
Stools: Hard Soft Formed Loose Sticky Black Blood Mucus Undigested Food
Floats Sinks Frequency of Bowel Movements _____ X [Day] [Week]

Genito-Urinary Tract - please circle any that you experience currently

Kidney Disease Painful Urination Blood in Urine Frequent Urination Incontinence
Nighttime Urination History of Kidney Stone Other: _____
Urine Color: Normal / Clear / Dark Yellow / Reddish / Cloudy
Urine Flow: Scanty / Has Odor / Burning / Painful / Difficult / Urgent

Musculoskeletal - please circle any that you experience currently

Do you have Pain? [Yes] [No] If yes please fill out the Pain Management Intake form.

Neurological Problems - please circle any that you experience currently

Vertigo/Dizziness Paralysis Numbness Loss of Balance Seizures Stroke Other: _____

Endocrine and Metabolic Disorders - please circle any that you experience currently

Hypothyroidism Hypoglycemia Hyperthyroidism Adrenal Burnout/Fatigue
Diabetes Mellitus Night Sweats Sweat Easily Weight Gain / Loss Other: _____

Sleep - please circle any that you experience currently

of Hours of Sleep: _____ Fall asleep _____ AM / PM Wake up _____ AM / PM

Difficulty Falling Asleep Why? _____

Difficulty Staying Asleep Waking When? _____ For How Long? _____

Dreams [Yes] [No] Sleep Quality [Good] [Poor] Wake Feeling Rested [Yes] [No]

Lifestyle -

a. Please indicate typical food and beverage intake:

Breakfast	Lunch	Dinner	Snacks

b. Quantity of Fluids Consumed Daily: Water _____ Other _____

c. Exercise – Type: _____ How Often: _____

d. Occupation/Employer: _____ Hours/Week: _____ Enjoy your work? [Yes] [No]

e. Nicotine and Tobacco Use Per Day: _____

f. Consumption Per Week – Alcohol: _____ Caffeine: _____

Female Reproductive - please circle any that you experience currently

Are you pregnant or is there any possibility you could be pregnant? [Yes] [No] # of Weeks _____

Number of Pregnancies _____ Live Births _____ Abortions _____ Miscarriages _____

Age of first period _____ Age of Menopause _____

Date last period began _____ Date of last PAP _____

Average number of days of flow _____ Average number of days in cycle _____

Is your menses regular? [Yes] [No] The flow is: [] Heavy [] Normal [] Light

Average # of tampons/pads used per day: 1st__ 2nd__ 3rd__ 4th__ 5th__ 6th__ 7th__

The color is: [] Fresh Red [] Dark Red [] Pale Red [] Purple [] Brown [] Other

Do you have the following menstruation related signs/symptoms?

[] Bleeding Between Cycles [] Nausea

[] Breast distension/tenderness [] PMS

[] Heavy vaginal discharge between periods [] Cramps

[] Pelvic Pain [] Infertility

[] Blood Clots - Approximate size and number _____

[] Menopausal Symptoms _____

Other: _____

Male Reproductive - please circle any that you experience currently

Premature Ejaculation External Genitalia have Sensations of: Cold / Numbness / Pain / Swelling

Impotence/Erectile Dysfunction Prostate Problems Other: _____

Other - please circle any that you experience currently

Anemia Cancer Rashes Eczema/Hives Cold Hands/Feet Prolapsed Organs

Is there anything else you'd like us to know about? _____