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HEALTH HISTORY

Patient Name: ____ Date: ____________

Street/Box: ______________________________Town _______________ State/Zip: _____________

Cell _____________ Home ______________ E-mail _______________________________________

DOB: ____________ Age: ______ Gender: __________ Height ___________ Weight ____________

Occupation: __________________________ Retired: _____ Disabled: _____ Unemployed ______

Emergency Contact Name & Phone Number: ____

How did you hear about this clinic? ____

Reason for Visit/Main Complaint(s):

1.

2.

3.

How long ago did this begin? ____

Have you consulted a physician? ____

Have you been given a diagnosis? If so, what: ____

What other forms of treatment have you tried? ____

Have you tried acupuncture before? ____

Past Personal Medical History: *Please circle all that apply to you*

Cancer Diabetes Asthma Allergies Diabetes Stroke

Heart Disease High Blood Pressure Seizures Thyroid Disease

Hepatitis A,B,C HIV Auto Immune Depression IBS

Pace Maker Kidney Disease Hysterectomy Prostate Issues

Significant Trauma, Auto Accidents, Injuries:____

____

Hospitalizations/Surgeries & Dates: ____

Allergies: ____

Other Significant Illnesses: ____

<u>Family Medical History</u>: *Please circle all that apply*

Cancer	Diabetes	Asthma	Allergies	Diabetes	Stroke
Heart Disease	High Blood Pressure	Seizures	Thyroid Disease		
Hepatitis A,B,C	HIV	Auto Immune	Depression	IBS	
Pace Maker	Kidney Disease	Hysterectomy	Prostate Issues		

<u>Medications</u> (prescription, OTC, vitamins/supplements, herbs, etc.): <u>Reason:</u>

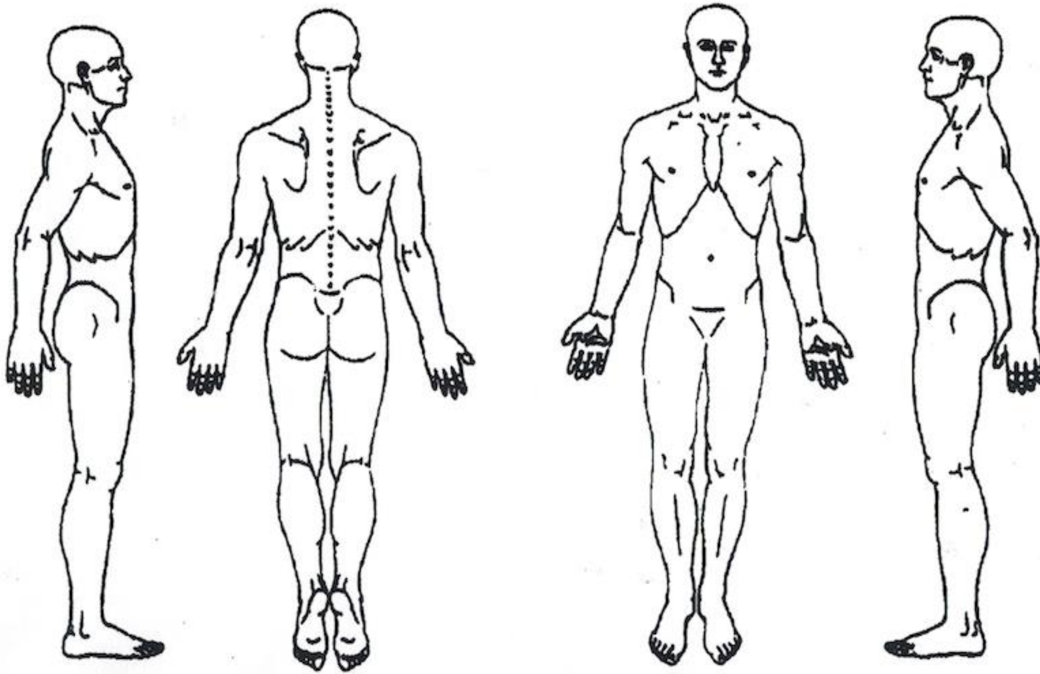
Average Diet:

<u>Morning</u> <u>Afternoon</u> <u>Night</u>

Daily Health Habits:

Do you smoke? Yes/No – If yes, how much?
How much alcohol do you drink in a week?
Describe any use of drugs for non-medical purposes:
How much soda do you drink in a week?
How much coffee or tea do you drink in a day?
How much water do you drink in a day?
Do you have a regular exercise program? Yes/No – Describe:
How many hours of sleep per night?

Please Indicate Areas of Pain:



Check any that apply currently or in the last 3 months:

General

▢Fevers	▢Strange Tastes or Smells	▢Poor Sleep
▢Sweats Easily	▢Cravings	▢Fatigue
▢Night Sweats	▢Change in Appetite	▢Sudden Energy Drop
▢Run Warm	▢Weight Loss	▢Bruise or Bleed Easily
▢Run Cold	▢Weight Gain	▢Strong Thirst

Skin & Hair

▢Rashes	▢Ulcerations	▢Hives
▢Itching	▢Acne/Pimples	▢Recent Moles
▢Dandruff	▢Eczema	▢Discoloration
▢Dry Skin	▢Psoriasis	▢Infection
▢Brittle Nails	▢Hair Loss	▢Other:

Head

☐Dizziness	☐Poor Vision	☐Migraines
☐Vertigo	☐Eye Pain	☐Headaches
☐Ringing in Ears	☐Eye Twitching	☐Sinus Congestion
☐Ear Pain	☐Cataracts	☐Sore Throats
☐Ear Blockage	☐Dry Eyes	☐Post Nasal Drip
☐Poor Hearing	☐Spots/Floaters in Vision	☐Nose Bleeds
☐Teeth Problems	☐Poor Night Vision	☐Cloudy/Fogginess
☐Teeth Grinding/Clenching	☐Facial Pain	☐Concussion
☐TMJ	☐Canker Sores/Mouth Ulcers	☐Other:

Cardiovascular

☐Chest Pain/Tightness	☐Fainting	☐Blood Clots
☐Irregular Heartbeat	☐Cold Hands or Feet	☐Palpitations
☐High/Low Blood Pressure	☐Swelling in Limbs	☐Varicose Veins

Respiratory

☐Cough	☐Asthma	☐Phlegm Production
☐Coughing of Blood	☐Difficulty Breathing	☐Pneumonia
☐Bronchitis	☐Wheezing	☐Shortness of Breath

Gastrointestinal

☐Nausea	☐Gas	☐Hemorrhoids
☐Vomiting	☐Belching	☐Blood in Stool
☐Indigestion	☐Diarrhea/Loose Stool	☐Black Stool
☐Acid Reflux/GERD	☐Constipation	☐Poor Appetite
☐Bloating	☐Sluggish Bowel	☐Excessive Appetit
☐Abdominal Distention	☐Abdominal Pain/Cramps	☐Hernia
☐Bleeding Gums	☐Rectal Pain/Burning	☐Laxative Use
☐Bad Breath	☐Undigested Food in Stool	☐Other:

Urinary

☐Frequent Urination	☐Pain with Urination	☐Weak Stream
☐Urgency to Urinate	☐Inability to Empty Bladder	☐Blood in Urine
☐Incontinence	☐Frequent UTIs	☐Kidney Stones
☐Dark Color to Urine	☐Strong Odor to Urine	☐Cloudy Urine
☐Frequent Night Urination	☐Other:	

Male Health

☐Impotence	☐Low Sperm Count	☐Low Libido
☐Premature Ejaculation	☐Low Motility	☐STDs
☐Enlarged Prostate	☐Testicular Pain	☐Other:

Female Health

Are you or is it possible that you are pregnant? Yes/No

Number of Pregnancies: Live Births: Miscarriages: Abortions:

Are you currently using birth control:

Age at First Period:	Duration of Period:	Length of Cycle:
▢Heavy Period	▢Uterine Fibroids	▢Vaginal Discharge
▢Light/Scanty Period	▢Ovarian Cysts	▢STDs
▢Painful Periods	▢Endometriosis	▢Fertility Issues
▢Breast Tenderness	▢Clots in Blood Flow	▢PMS
▢Period Begins with Spotting	▢Frequent Yeast Infections	▢Spotting
▢Hesitant Start to Period	▢Polycystic Ovarian Syndrome	▢Irregular Cycle

Musculoskeletal

▢Neck Pain	▢Hand/Wrist Pain	▢Shoulder Pain
▢Back Pain	▢Foot/Ankle Pain	▢Sciatica
▢Hip Pain	▢Overall Muscle Ache	▢Muscle Weakness
▢Knee Pain	▢Herniated Discs	▢Other:

Neurological

▢Seizures	▢Dizziness/Vertigo	▢Confusion
▢Stroke	▢Loss of Balance	▢Tremors
▢Concussion	▢Areas of Numbness	▢ADD/ADHD
▢Poor Memory	▢Neuropathy/Nerve Pain	▢Poor Coordination
▢Other:		

Emotions

▢Depression	▢Insomnia/Mind Racing	▢Panic Attacks
▢Anxiety	▢Fear/Phobias/Worry	▢Nervousness
▢Anger/Temper	▢Easily Susceptible to Stress	▢Other:

Are you currently being treated for emotional or psychological issues?

Have you ever considered or attempted suicide?