Acupuncture & Natural Healing Therapies

Patient Health History

This Information is Confidential

Name: _____ Date: _____/_____/_____
(first) (middle) (last)

Address: _____

Phone (home/work): _____ Referred By: _____

Date of Birth: _____/_____/_____ Gender: M / F Marital status: S M D W

Emergency Contact Name and Phone Number:_____

Height: _____ Weight: _____ Date of latest visit to your physician _____

What was your most recent blood pressure reading? _____/_____ When was this reading taken? _____

1. Please describe your main health concern(s) and how long you've had them:

_____

_____

_____

_____

_____

_____

2. Please list foods, drugs, or medications you are hypersensitive or allergic to:

_____

_____

_____

3. Please list medications, vitamins, and supplements you are currently taking:

_____

_____

_____

4. Do you have any reason to believe you may be pregnant? Y N If so, how far along are you? _____

5. Do you have any infectious diseases? Y N If so, please identify: _____

6. **Family History:**	Father	Mother	Brothers	Sisters	Children
Age (if living)	_____	_____	_____	_____	_____
Health (G=Good, P=Poor)	_____	_____	_____	_____	_____
Check those applicable:					
Cancer	_____	_____	_____	_____	_____
Diabetes	_____	_____	_____	_____	_____
Heart Disease	_____	_____	_____	_____	_____
High Blood Pressure	_____	_____	_____	_____	_____
Stroke	_____	_____	_____	_____	_____
Mental Illness	_____	_____	_____	_____	_____
Asthma/Hay fever/Hives	_____	_____	_____	_____	_____
Kidney Disease	_____	_____	_____	_____	_____
Age (at death)	_____	_____	_____	_____	_____
Cause of Death	_____	_____	_____	_____	_____

7. **Childhood Illness** (please circle any that you have had):

Scarlet Fever Diphtheria Rheumatic Fever Mumps Measles German Measles

Chicken Pox Others:_____

8. **Immunizations** (please circle any that you have had and note any abnormal reactions):

Polio Tetanus Rubella/Mumps/Rubella Pertussis Diphtheria Hib

Hepatitis Others: _____

9. **Hospitalizations, Surgeries, Accidents:**_____

_____

_____

_____

_____

10. **X-Rays/CAT Scans/MRI's/NMR's/Special Studies:** _____

_____

_____

_____

PATIENT NAME: _____

Please circle any that you experience now and underline any that you have experienced in the past.

11. **Skin** _____

Eczema Acne Rashes Dermatitis Furuncles Fungal infections Warts Psoriasis Hives

12. **Head, Eye, Ear, Nose, and Throat** _____

Migraines Frequent Headaches Sinus Headaches Sinus Problems/Congestion
Impaired Vision Eye Pain/Strain Glaucoma Tearing/Dryness Glasses/Contacts
Ear Ringing Decreased Hearing Deafness Earaches Ear Infections Itchy Ears
Nose Bleeds Post-Nasal Drip Stuffy Nose Sneezing/Hay Fever
Frequent Sore Throats Dry Throat Itchy Throat Difficulty swallowing

13. **Oral** _____

Bleeding gums Periodontitis Dental Abscess Mouth Inflammation TMJ Toothache Teeth Grinding

14. **Respiratory** _____

Pneumonia Frequent Colds Painful Breathing Shortness of Breath Emphysema Asthma
Cough/Wheezing Pleurisy Bronchitis Tuberculosis Lung Abscess

15. **Heart and Vascular** _____

Fast pulse (over 100 beats/min) Slow pulse (less than 60 beats/min) Irregular pulse Anemia Blood Disease
Heart Disease Chest Pain/Pressure Swelling (Legs/Ankles/Hands/Face) High/Low Blood Pressure
Palpitations Stroke Heart Murmurs Rheumatic Fever Spider Veins Varicose Veins

16. **Gastrointestinal** _____

Ulcer Changes in Appetite Nausea/Vomiting Indigestion Passing Gas Heartburn
Belching Gall Bladder Disease Liver Disease Hepatitis B or C Hemorrhoids Stomach Pain
Constipation Diarrhea Gastritis Lack of Stomach Acid Ileocecal Valve Spasm
Peritonitis Pancreatitis Irritable Bowel Polyps Tumor Colitis Crohn's

17. **Genito-Urinary Tract** _____

Kidney Disease Painful Urination Frequent UTI Frequent Urination Heavy Flow
Kidney Stones Impaired Urination Blood in Urine Frequent Urination at Night

18. **Female Reproductive** _____

Age of First Period: _____ Age of Menopause:_____ Number of Pregnancies: _____Birth Control Type: _____
Date of Last Period: _____ Duration of Period: _____ Days between Periods: _____
Irregular Cycles Breast Lumps/Tenderness Nipple Discharge Heavy/Light Flow
Vaginal Discharge Premenstrual Problems Clotting Bleeding Between Cycles
Menopausal Symptoms Difficulty Conceiving Painful Periods Low/High Libido

19. **Male Reproductive** _____

Sexual Difficulties Prostrate Problems Testicular Pain/Swelling Penile Discharge
Low/High Libido Impotence Premature Ejaculation Infertility

Please circle any that you experience now and underline any that you have experienced in the past.

20. **Musculoskeletal** _____

Neck/Shoulder Pain Muscle Spasms/Cramps Arm Pain Upper Back Pain Mid Back Pain
Low Back Pain Leg Pain Joint Pain (where?): _____

21. **Neurologic** _____

Vertigo/Dizziness Paralysis Numbness/Tingling Loss of Balance Seizures/Epilepsy

22. **Autoimmune/Inflammatory/Hormonal Conditions** _____

Thyroid (Hypo/Hyper) Rheumatism/Arthritis Lupus Colitis Crohn's Disease Allergies
Atopic Dermatitis Neurodermatitis Cellulitis Sinusitis Vulvitis
Low Immunity Myofascial Pain Syndrome Fibromyalgia Tendinitis Plantar Fasciitis
Constant Low Fever Frequent Infections Swollen glands Diabetes Mellitus
Hypoglycemia

23. **Lifestyle:**

a. Do you typically eat at least three meals per day? Y / N Describe your diet: _____

_____

b. What beverages do you drink daily? _____

c. Interests, hobbies, exercise _____

d. How many hours per night do you sleep? _____ Do you wake rested? Y N

e. Occupation: _____ Work Hours/Week: _____

Do you enjoy work? Y / N Why/Why not?_____

f. Nicotine/Alcohol/Caffeine/Drug Use:_____

24. Have you experienced any major emotional or birth trauma? Y N Explain: _____

_____

25. Is there anything else you think we should know? _____

_____

_____

How did you hear about us? _____

Would you like to receive reminders for future appointments? Yes No

If yes: Contact phone number:_____

Email address: _____