Patient Health History

Successful health care and preventative medicine are only possible when the practitioner has a complete understanding of you physically, mentally and emotionally. Please complete this questionnaire as thoroughly as possible. All of your answers will be held absolutely confidential. If you have questions, please ask. Thank you for committing to your health by being here today.

Name:(first) (middle)	Today's Date: / /
	(last)
Email:	Referred by:
Best Telephone:	Please circle: Home / Work / Cell phone
Mailing Address:	
Date of Birth: /	Place of Birth:
Age: Height: Weight:	Gender: Male / Female Occupation:
Marital status: Single / Married / Par	tnered / Separated / Divorced / Widowed Date:
Emergency Contact:	Relationship to you: Phone:
Primary Care Physician (and phone): _	
1. Please indicate below what you wo	ould like to work on with me, in order of importance to you:
<u>Condition</u>	Past Treatment
a	
How does this condition affect you? _	
b	
C	
How does this condition affect you? _	
2. Have you ever used Chinese medic	cine for your health care? For what reason?

Patient Name: Today's Date:	
Others:	
Immunizations: Polio / Tetanus / Measles/Mumps/Rubella / Diphtheria / Pertussis / Hepatitis B / Hib/Flu	
Childhood Illness: Mumps / Measles / German Measles (Rubella) / Diphtheria / Chicken Pox / Rheumatic Fe	ver
Surgical implants / Pacemaker / HIV / Hepatitis / Pregnant / Cancer / Diabetes / Hypertension	
8. Please circle any that apply to you (write date above it):	
	_
7. If applicable, please list any foods, drugs, or medications you are hypersensitive or allergic to (please incl reaction):	- abr
	_
taking, for what reason and for how long:	_
6. Please list any medications (prescribed and over-the-counter), vitamins, and supplements you are currently	_
	_
5. Please list dates and briefly describe any significant life experiences (e.g. car accidents, divorce, death in family, injury, assaults, etc – please include any details surrounding your birth/mother's pregnancy with you):	
	_
had:	_
4. Please list approximate dates and briefly describe any hospitalizations, surgeries or major illnesses you ha	- ve
	_
3. When and where did you last receive health care? For what reason?	

9. Any X-Rays/CAT Scans/MRI's/NMR's/Sp	ecial Studies? When? For what reason?
10. Diet & Lifestyle:	
List when and what you ate yesterday:	
Breakfast (time):	
Lunch (time):	
Snacks (time):	
Circle day or week, and indicate number a	
Alcohol: # drinks per day/week	Type:
Tobacco: # per day/week	Type:
Coffee/Tea: # cups per day/week	Type:
Soda: # drinks per day/week	Type:
Fast Food: # per day/week	Type:
TV/Video/Computer: hours per da	ay/week Type:
Exercise: Type: How lon	g? Times per day/week:
Sleep: hours per night /	naps per day / Do you wake feeling rested? Y / N
How many times do you wake in the night	? / Can you fall back to sleep?
Describe your energy levels:	
Spiritual Practice:	
	:
Patient Name	Today's Date:

			Bro/Sis	Bro/Sis	Bro/Sis	Matern	Matern	Patern	Patern	ç	ion/Daug	Son/Daug
	Mom	Dad			Sibling 3		G'Dad	G'Mom	G'Dad	Spouse		Child
Good Health												
Cancer												
Heart Disease												
High Blood Pressure												
Stroke												
Diabetes												
Thyroid Disorders												
Anemia												
Musculoskeletal												
Mental Illness												
Emotional Disorders												
Alcohol/Drug Use												
Asthma/Allergies												
Kidney Disease												
Autoimmune												
Other:												
Adopted												
Age (current or at death)												
Cause of Death												

13. Your Health (please check any you are experiencing now or in the past, and when it started & how long it lasted):

Glasses/Contacts Blurred Vision Dryness Redness, itching, pain Excessive tearing Spots or floaters Double vision Other (please describe): Difficulty staying asleep Disturbing or redness Discharge Discharge Discharge Discharge Discharge Discharge Discharge Allergies Sinus infection Dryness Dry nose Dry or old please Dry nose Dry or old please Dry nose	Eyes			Other (please describe):	Neck/Back:	
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Patient Name: ______ Date: _____

Gastrointe	estinal - Con't _ Sluggish digestion _ Abdominal pain _ Change in weight	Incontinence Kidney stones Other (please describe):	Vaginal discharge (describe): Breast tenderness
	Altered taste Bad breath Diarrhea/loose stool Constipation Difficult bowel movements Laxative dependence Blood in stool Hypoglycemia	Reproductive (male & female) Low or high libido Pain or itching genitals Genital discharge or lesions Other (please describe):	Breast lumps Painful intercourse Abnormal pap smear Vaginal infections Uterine fibroids Endometriosis Ovarian cysts Birth control type Other (please describe):
Have you		Pregnant (current/possible) # of pregnancies # of live births # of miscarriages # of abortions Age at first period Age at menopause Painful periods Irregular periods Heavy or light blood flow Menstrual blood clots al diagnoses (include dates and mediate about yourself or your goals for	
What is y	our favorite time of year and	d why?	
How did	you hear about HS-Acupunct	ure?	
Would yo	ou like to receive email newsl	etters / announcements / reminders	?
How wou	ld you like to be reminded o	f your next appointment? Phone ca	ll / Email / No reminder needed
		r body thanks you for your commitme	
Patient Na	me:	Today's Date:	