HS-ACUPUNCTURE

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: ____ Today's Date: _____ /_____ /_____
(first) (middle) (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 / Partnered / Separated / Divorced / Widowed Date: ______________

Emergency Contact: __________________ Relationship to you: ____________ Phone: ____________

Primary Care Physician (and phone): ____

1. Please indicate below what you would like to work on with me, in order of importance to you:

Condition Past Treatment

a. __________________________ ____

How does this condition affect you? ____

b. __________________________ ____

How does this condition affect you? ____

c. __________________________ ____

How does this condition affect you? ____

2. Have you ever used Chinese medicine for your health care? For what reason?

____

____

3. When and where did you last receive health care? For what reason?

____

____

4. Please list approximate dates and briefly describe any hospitalizations, surgeries or major illnesses you have had: ____

____

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):

____

____

____

6. Please list any medications (prescribed and over-the-counter), vitamins, and supplements you are currently taking, for what reason and for how long: ____

____

____

7. If applicable, please list any foods, drugs, or medications you are hypersensitive or allergic to (please include reaction): ____

____

____

8. Please circle any that apply to you (write date above it):

Surgical implants / Pacemaker / HIV / Hepatitis / Pregnant / Cancer / Diabetes / Hypertension

Childhood Illness: Mumps / Measles / German Measles (Rubella) / Diphtheria / Chicken Pox / Rheumatic Fever

Immunizations: Polio / Tetanus / Measles/Mumps/Rubella / Diphtheria / Pertussis / Hepatitis B / Hib/Flu

Others: ____

Patient Name: ______________________________ ***Today's Date:*** ______________

9. Any X-Rays/CAT Scans/MRI's/NMR's/Special Studies? When? For what reason? ____________________________

____

____

10. **Diet & Lifestyle**:

List when and what you ate *yesterday*:

Breakfast (time): ____

Lunch (time): ____

Dinner (time): ____

Snacks (time): ____

Circle day or week, and indicate number and type below:

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 day/week Type: ____

Exercise: Type: _________________ How long? _________________ 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: ____

Hobbies/Ways You Relax/Favorite Activities: ____

____

How do you manage stress? ____

Patient Name: ____ ***Today's Date:*** ___________________

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11. **Family History**:

Do you have any children? Y / N   Do they live with you? Y / N   List ages and gender: ___________________

Are they in good health? Y / N / Explain: ____

Please circle any health conditions that apply to your immediate family's medical history (circle gender):

	Mom	Dad	Bro/Sis Sibling1	Bro/Sis Sibling2	Bro/Sis Sibling 3	Matern G'Mom	Matern G'Dad	Patern G'Mom	Patern G'Dad	Spouse	Son/Daug Child	Son/Daug 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												

Please share any other information or comments you feel might be helpful: _________________________________

____

____

Patient Name: ____ ***Today's Date:*** __________________

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

Eyes

__________ Glasses/Contacts
__________ Blurred Vision
__________ Dryness
__________ Redness, itching, pain
__________ Excessive tearing
__________ Spots or floaters
__________ Double vision
__________ Glaucoma
__________ Cataracts
__________ Other (please describe):
____

Ears

__________ Hearing loss
__________ Ringing
__________ Earache
__________ Discharge
__________ Other (please describe):
____

Nose, Throat, Mouth

__________ Nasal congestion
__________ Phlegm or discharge
__________ Allergies
__________ Sinus infection
__________ Postnasal drip
__________ Frequent cold/flu
__________ Nosebleed
__________ Dry nose
__________ Dry mouth
__________ Sores or swellings
__________ Dental/gum problems
__________ Jaw tension/tightness
__________ Teeth grinding
__________ Facial pain
__________ Dry or sore throat
__________ Strong thirst
__________ Difficulty swallowing
__________ Loss of voice
__________ Loss of smell
__________ Other (please describe):
____

Hot and Cold

__________ Feel hot or cold (most days)
__________ Cold hands or feet
__________ Desire: hot/cold food/drink
__________ Cold or hot flashes

__________ Other (please describe):
____

Head and Neck

__________ Headache
__________ Stiff neck
__________ Dizzy or fainting
__________ Vertigo
__________ Swelling
__________ Other (please describe):
____

Skin

__________ Acne/pimples
__________ Rashes or hives
__________ Eczema/psoriasis
__________ Itching or redness
__________ Dry or oily skin
__________ Abnormal sweating
__________ Easy bruising
__________ Lumps or swellings
__________ Varicose veins
__________ Other (please describe):
____

Chest

__________ Difficulty breathing
__________ Frequent sighing
__________ Chronic cough/wheezing
__________ Cough blood or mucous
__________ Tight or stuffy chest
__________ Pneumonia or Bronchitis
__________ Palpitations
__________ Rapid/irregular heartbeat
__________ Chest Pain
__________ High or low blood pressure
__________ Heart murmur
__________ Heart disease
__________ Other (please describe):
____

Body and Limbs

__________ Heaviness or stiffness
__________ Limited range of motion
__________ Numbness or tingling
__________ Paralysis
__________ Seizures or tremors
__________ Spasms or cramps
__________ Pains (list in next column):

Neck/Back: ________________________
Arm/Leg: ________________________
Shoulder/Hip: ________________________
Elbow/Knee: ________________________
Wrist/Ankle: ________________________
Hand/Foot: ________________________
Other: ________________________

Sleep and Energy

__________ Difficulty falling asleep
__________ Difficulty staying asleep
__________ Disturbing dreams
__________ Waking due to pain
__________ Nightsweats
__________ Fatigue or energy drops
__________ Restlessness or hyperactivity
__________ Waking to urinate
__________ Other (please describe):
____

Mental and Emotional

__________ Poor memory
__________ Foggy headedness
__________ Difficulty focussing
__________ Depression
__________ Mood swings
__________ Irritability/frustration/anger
__________ Difficulty relaxing
__________ Loneliness
__________ Sensitivity
__________ Shyness
__________ Frequent crying
__________ Worry
__________ Anxiety / panic attacks
__________ Compulsive behaviors
__________ Suicidal thoughts
__________ Eating disorder
__________ Other (please describe):
____

Gastrointestinal

__________ Low or excessive appetite
__________ Bloating or flatulence
__________ Abdominal heaviness
__________ Nausea or vomiting
__________ Belching or hiccupping
__________ Heartburn or reflux

Continued on next page...

Patient Name: ____ ***Date:*** __________________

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Gastrointestinal - *Con't...*

___________ Sluggish digestion
___________ Abdominal pain
___________ Change in weight
___________ Altered taste
___________ Bad breath
___________ Diarrhea/loose stool
___________ Constipation
___________ Difficult bowel movements
___________ Laxative dependence
___________ Blood in stool
___________ Hypoglycemia
___________ Other (please describe):
____

Urinary

___________ Urinary tract/kidney infections
___________ Burning/hot urine
___________ Cloudy urine
___________ Frequent or urgent urine
___________ Strong odor
___________ Blood in urine
___________ Disrupted flow
___________ Incomplete emptying
___________ Difficult urination
___________ Incontinence
___________ Kidney stones
___________ Other (please describe):
____

Reproductive (male & female)

___________ Low or high libido
___________ Pain or itching genitals
___________ Genital discharge or lesions
___________ Other (please describe):
____

Female

___________ 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
___________ Vaginal discharge (describe):
____
___________ Breast tenderness
___________ Breast lumps
___________ Painful intercourse
___________ Abnormal pap smear
___________ Vaginal infections
___________ Uterine fibroids
___________ Endometriosis
___________ Ovarian cysts
___________ Birth control type
___________ Other (please describe):
____

Male

___________ Impotence
___________ Premature ejaculation
___________ Nocturnal emissions
___________ Lumps in testicles
___________ Hernia
___________ Enlarged prostate
___________ Other (please describe):
____

Have you received any Western medical diagnoses (include dates and medications prescribed)?
____
____

Is there anything else you want to share about yourself or your goals for your health?
____
____

What is your favorite time of year and why?
____

How did you hear about HS-Acupuncture? ____

Would you like to receive email newsletters / announcements / reminders ? ______________________

How would you like to be reminded of your next appointment? Phone call / Email / No reminder needed

THANK YOU for your time today. Your body thanks you for your commitment to your health and well being. ☺

Patient Name: ______________________________ ***Today's Date:*** ______________