



**Confidential Patient Health History**

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Gender: M / F

Marital Status (please circle): Single Married Life Partner Divorced Widowed

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Occupation: \_\_\_\_\_ Email: \_\_\_\_\_

How did you hear about us? \_\_\_\_\_

**Emergency contact:**

Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Relationship to you: \_\_\_\_\_

Have you had acupuncture before? Y / N    Massage? Y / N    For what condition? \_\_\_\_\_

**Reason for your visit today:** \_\_\_\_\_

How and when did this condition begin? \_\_\_\_\_

What types of treatments have you tried? \_\_\_\_\_

Please list main health concerns you would like to be free of, in order of importance:

- 1 \_\_\_\_\_
- 2 \_\_\_\_\_
- 3 \_\_\_\_\_

Please list all medications, supplements, herbs and/or vitamins you are taking, current dose, and for what condition:

\_\_\_\_\_  
\_\_\_\_\_

Please list any known allergies and reactions (seasonal, environmental, food, medication, or otherwise):

\_\_\_\_\_

Any surgeries, major illnesses, hospitalizations, and major falls/accidents/traumas – include dates:

\_\_\_\_\_  
\_\_\_\_\_

**HEALTH HISTORY** (please check only the conditions that apply to you):

- |  |   |  |   |
|--|---|--|---|
| <input type="checkbox"/> AIDS/HIV            | <input type="checkbox"/> Diabetes         | <input type="checkbox"/> High Blood Pressure       | <input type="checkbox"/> Thyroid issues               |
| <input type="checkbox"/> Alcoholism          | <input type="checkbox"/> Eating disorder  | <input type="checkbox"/> Kidney Disease            | <input type="checkbox"/> Tuberculosis                 |
| <input type="checkbox"/> Allergies           | <input type="checkbox"/> Emphysema        | <input type="checkbox"/> Liver disease             | <input type="checkbox"/> Ulcers                       |
| <input type="checkbox"/> Anemia              | <input type="checkbox"/> Epilepsy         | <input type="checkbox"/> Low blood pressure        | <input type="checkbox"/> Venereal dis.                |
| <input type="checkbox"/> Arthritis           | <input type="checkbox"/> Fracture         | <input type="checkbox"/> Migraine                  | <input type="checkbox"/> Other (please specify) _____ |
| <input type="checkbox"/> Asthma              | <input type="checkbox"/> Glaucoma         | <input type="checkbox"/> Mononucleosis             | _____   |
| <input type="checkbox"/> Auto-immune dis.    | <input type="checkbox"/> Gallstones       | <input type="checkbox"/> Multiple Sclerosis        | _____   |
| <input type="checkbox"/> Bleeding disorder   | <input type="checkbox"/> Gout             | <input type="checkbox"/> Mental Illness            | _____   |
| <input type="checkbox"/> Breast Cysts        | <input type="checkbox"/> Headaches        | <input type="checkbox"/> Osteoporosis              | _____   |
| <input type="checkbox"/> Bronchitis          | <input type="checkbox"/> Heart disease    | <input type="checkbox"/> Pacemaker                 | _____   |
| <input type="checkbox"/> Bipolar             | <input type="checkbox"/> Heart murmur     | <input type="checkbox"/> Parkinson's               |   |
| <input type="checkbox"/> Cancer              | <input type="checkbox"/> Hepatitis        | <input type="checkbox"/> Pneumonia                 |   |
| <input type="checkbox"/> Candida(yeast)      | <input type="checkbox"/> Hernia           | <input type="checkbox"/> Prostate problems         |   |
| <input type="checkbox"/> Chemical dependency | <input type="checkbox"/> Herniated disc   | <input type="checkbox"/> Stroke                    |   |
| <input type="checkbox"/> Colitis             | <input type="checkbox"/> Herpes           | <input type="checkbox"/> Substance Addiction/abuse |   |
| <input type="checkbox"/> Chicken Pox         | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Suicide attempt           |   |

**FEMALE REPRODUCTIVE** ( please check all that apply):

- | NOW                      | PAST                     |                         | NOW                      | PAST                     |                               |
|--------------------------|--------------------------|-------------------------|--------------------------|--------------------------|-------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Lumps in breast         | <input type="checkbox"/> | <input type="checkbox"/> | Painful sex                   |
| <input type="checkbox"/> | <input type="checkbox"/> | Nipple discharge        | <input type="checkbox"/> | <input type="checkbox"/> | Lack of sexual desire         |
| <input type="checkbox"/> | <input type="checkbox"/> | Breast pain             | <input type="checkbox"/> | <input type="checkbox"/> | Menstruation excessive        |
| <input type="checkbox"/> | <input type="checkbox"/> | Pelvic pain             | <input type="checkbox"/> | <input type="checkbox"/> | Menstruation absent           |
| <input type="checkbox"/> | <input type="checkbox"/> | Discharge from vagina   | <input type="checkbox"/> | <input type="checkbox"/> | Bleed or spot between periods |
| <input type="checkbox"/> | <input type="checkbox"/> | Vaginal itching/burning | <input type="checkbox"/> | <input type="checkbox"/> | Genital eruptions             |

Have you ever used birth control pills? Y / N Type and for how long? \_\_\_\_\_

Have you ever used an I.U.D.? Y / N For how long? \_\_\_\_\_

Hormone Replacement therapy? Y / N

Are you currently sexually active? Y / N if not, have you been sexually active in the past? Y / N

Current form(s) of contraception \_\_\_\_\_

Please check any that apply:

- menopausal     post-menopause     endometriosis     polycystic ovary disease     pelvic inflammatory disease

Age when menstrual periods began \_\_\_\_\_

Period every \_\_\_\_\_ days. Are they regular? Y/N

Periods usually last \_\_\_\_\_ days (average) Date of last period \_\_\_\_\_

Please circle: Menses is usually: light / moderate / heavy

I use: tampons / pads / combination Level of absorbency? \_\_\_\_\_

Please put a B if before period, D if during period, or a A if after period:

- |                               |  |
|-------------------------------|--|
| ____ abdominal cramping       | ____ crying/weepy                                      |
| ____ backache                 | ____ anger   |
| ____ water retention/bloating | ____ irritable   |
| ____ breast tenderness        | ____ anxiety   |
| ____ headache/migraine        | ____ mood changes                                      |
| ____ depression               | ____ hypersensitivity                                  |
| ____ lethargy                 | ____ prefer to be left alone                           |
| ____ sadness                  | ____ inability to concentrate                          |
| ____ clotting                 | ____ loose stool/diarrhea                              |
| ____ food cravings            | ____ other symptoms not listed, please describe: _____ |

Date of last PAP smear \_\_\_\_\_ Was it normal? Y / N

If not, please explain: \_\_\_\_\_

Have you ever been diagnosed with HPV? Y / N

Do you currently, or have had in the past, problems with infertility? Y / N

If yes, explain \_\_\_\_\_

Have you experienced \_\_\_\_\_ miscarriage? \_\_\_\_\_ abortion?

Number of children: \_\_\_\_\_ their age(s): \_\_\_\_\_

Number of: pregnancies \_\_\_\_\_ births \_\_\_\_\_ miscarriages \_\_\_\_\_ abortions

Any complications of pregnancy? \_\_\_\_\_ If yes, explain \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**MALE REPRODUCTIVE** ( please check all that apply):

NOW PAST

- Prostate problems
- Swelling, lumps and pain in testicles
- Discharge from penis
- Infertility

NOW PAST

- Painful erection
- Difficult achieving and maintaining erection
- Difficult ejaculation

Are you currently sexually active? Y / N If not, you been sexually active in the past? Y / N

Type(s) of contraception used? \_\_\_\_\_

## CHINESE BODY SYSTEMS REVIEW

Traditional Chinese Medicine takes into account the well being of the entire person, not just the presenting symptoms.

Please check all that apply to you within the past 3 months:

I tend to feel:  hot  cold  thirsty  I prefer cold drinks  I prefer hot drinks

I experience:  chronic fatigue  weakness  heaviness of head /limbs  dizziness  
 mental fog  difficulty concentrating  poor memory  insomnia  
 disturbing dreams  palpitations  ringing in the ears  hot flashes  
 night sweats  low libido  dry/sore throat  frequent throat clearing  
 bitter taste in mouth  excessive need for sleep  difficulty losing, gaining, or regulating weight

I have a tendency toward the following emotions:  
 frustration  irritability  worry  over thinking  anger  
 panic  sadness  feeling stuck  fear  anxiety  
 hopelessness

DIGESTION:  low appetite  excessive hunger  gas /bloating after meals  
 heartburn / acid reflux  belching  nausea  nervous stomach  
 mouth sores / ulcers  constipation  dry hard stools  loose stools  
 fluctuates between constipation and loose stools or diarrhea  early morning diarrhea  hemorrhoids

URINARY:  frequent urination  scanty urination  incontinence  history of UTIs  
 urinating more than once per night

RESPIRATORY:  susceptible to colds /flus /allergies  sinus congestion  chronic cough  
 dry nose / mouth /throat heaviness of chest  shortness of breath  
 difficulty in taking nice full deep breaths  frequent sighing

SKIN:  dry skin  eczema  psoriasis  fungal /yeast infections  
 hair loss  cold hands /feet  spontaneous sweating  heat sensation palms /soles

MUSCULAR /SKELETAL:  neck /shoulder tension  low back pain  sore /weak knees  
 tenderness in muscles  muscle spasms  numbness /tingling  jaw pain  
 joint pain  popping /cracking of joints  sciatica  feel better after exercise  
 feel worse after exercise

LIFESTYLE: Do you follow a specific diet? Y / N If so, please explain: \_\_\_\_\_  
How often do you exercise? \_\_\_\_\_ What type(s) of exercise \_\_\_\_\_  
Do you make time for relaxation / meditation / prayer? Y / N  
How many hours of sleep do you typically get? \_\_\_\_\_ Do you wake rested? Y/N  
Do you have trouble falling or staying asleep? Y/N  
Please check all that apply : \_\_\_ coffee / caffeine \_\_\_ sugar \_\_\_ alcohol \_\_\_ smoking \_\_\_ recreational drugs

Thank you for taking the time to fill out this health history. Please read below and sign:

*The above information is true, accurate and complete to the best of my knowledge. I will make my practitioner aware of any changes to any and all of the information above.*

Signature \_\_\_\_\_ Date: \_\_\_\_\_