YOUR HEALTH HISTORY

Name____Date________________

Address__________________________________
City_________________Zip Code________

Phone (H)_____________________(W)___________________(Cell)__________________

Birth date________ Age_________ Occupation_____________________________

E mail __________________________________ Referred by _______________________
How did you hear about us? _________________________
Physician___________________Clinic___________________________
Notify in case of
emergency___________________________________Phone______________

ALL INFORMATION IS CONFIDENTIAL.

Please identify your health concerns in order of importance below:

1)

2)

3)

Illnesses/Western Medical Diagnoses & **Medications, Injuries & Surgeries**:

______________________________ ________________________________
______________________________ ________________________________
______________________________ ________________________________
______________________________ ________________________________
______________________________ ________________________________
______________________________ ________________________________

Significant Trauma (include accidents, divorce/ending of relationships, etc.)
Year Type
_________ ____
_________ ____
_________ ____
_________ ____

Family Medical History (circle where appropriate, indicate family member)

Diabetes	Heart Disease	Cancer
Stroke	Allergies	High blood pressure
Seizures	Drug and/or	Mental illness
Asthma	alcohol addiction	Gall bladder problems

Do you have a pacemaker?

Do you have any bleeding disorders?

Lifestyle:
How many hours of sleep per night?
Do you have regular mealtimes? Are they relaxed?

Do you eat "ON THE GO" WHEN READING WATCHING TV WHILE WORKING?

How much do you drink per day of?
COFFEE TEA POP ALCOHOL (per week) WATER

Describe your "junk food" intake:
NEVER INFREQUENT DAILY HEAVY

Describe your sugar usage (on food, drinks, candy, sweets, etc)
NEVER INFREQUENT DAILY HEAVY

Children's names and ages:

Do you consider yourself to have a healthy psychological self-image?

Have you experienced: SEXUAL ASSAULT PHYSICAL ABUSE
(Circle and indicate when) SEXUAL ABUSE VERBAL ABUSE

Do you have any regular spiritual practices? Meditation?

How many jobs do you have? Do you enjoy your work?

How would you characterize your primary relationships? (Spouses/partners, friends, etc.)

Do you have a happy home life?

Good work environment?

Will you receive any support when necessary for any changes in your health/lifestyle?

What are the primary stresses in your life?

Do you take time off work and/or make time to relax regularly?

Do you exercise regularly? Yes No If so what & how often?____________________

Please check the following conditions that you experience either occasionally or frequently:

Energy	Occasional	Frequent	**Sleep**	Occasional	Frequent
Fatigue (morning)			Trouble falling asleep		
Fatigue (afternoon)			Wake up a lot		
Fatigue (evening)			Wake early		
Wake refreshed			Pleasant dreams		
Wake unrefreshed			Nightmares		

Temperature	Occasional	Frequent		Occasional	Frequent
General warmth			General cold/ chills		
Night sweats			Cold hands/feet		
Warm at night			Hot flashes		
Perspire easily			Areas of numbness		

Classical Acupuncture & Herbs

Emotions	occasional	frequent		occasional	frequent
Stress/anxiety			Dull unclear thinking		
Panic attacks			indecisive		
worry			Poor memory		
fearful			obsessive		
phobias			bipolar		
depressed			Manic tendencies		
Bad temper			Sadness/grief		
irritable					

Head/eyes/ears	occasional	frequent		occasional	frequent
Eyes:(circle) blurry, itchy, dry, red, floaters			Postnasal drip		
Sinus congestion			Dry mouth		
Sinus headache			Jaw pain		
Sore throat			Dental problems		
colds			Mouth sores		
Tension headaches			seizures		
migraines			dizziness		
Lump in throat			Ears ringing		

Chest/Lung/Heart	occasional	frequent		occasional	frequent
cough			Heart races		
asthma			Heart skips		
Chest colds			Heart murmur		
Chest pain			Hard to breathe		

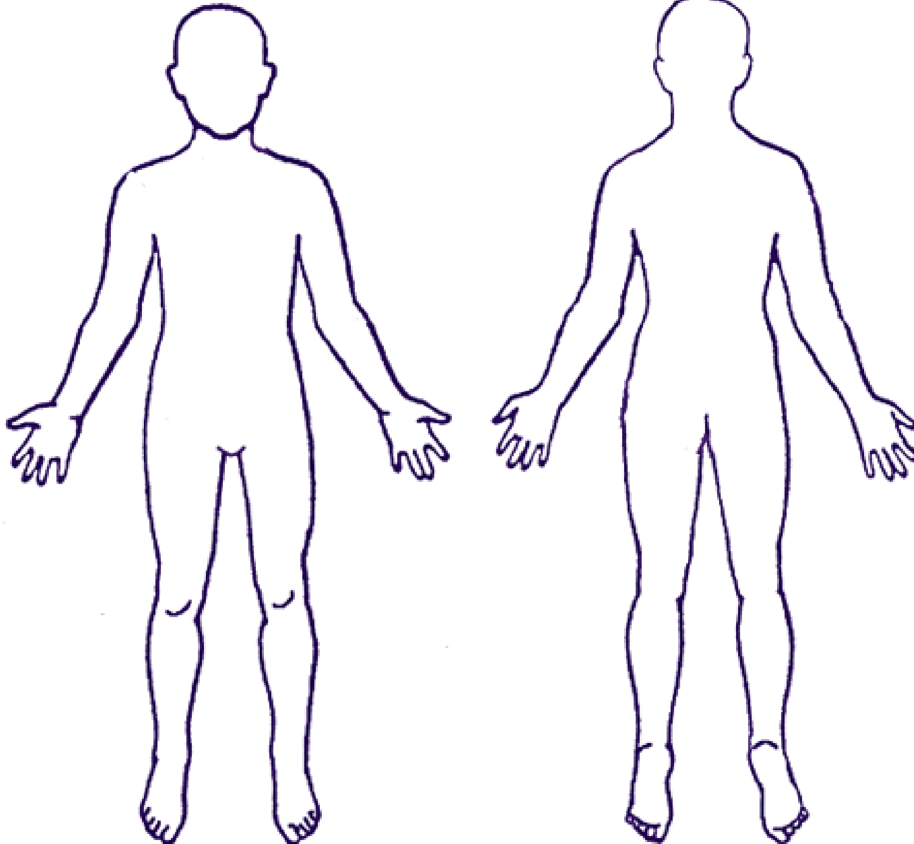
Digestion	Occasional	frequent		Occasional	frequent
Bloating			Hard stools		
Belching			Constipation		
Reflux			Loose stools		
gas			Watery stools		
nausea			vegetarian		
vomiting			Special diet		
Good appetite			Weight gain		
Poor appetite			Weight-loss		
Abdominal cramps			Prolapsed organs (which?)		
hemorrhoids			Pain under ribs		
IBS			Tired after eating		

Urination	Occasional	frequent		Occasional	frequent
Frequent			Burning urination		
Up at night			Can't control		
cloudy			infections		

Limbs/Back	Occasional	Frequent		Occasional	frequent
Muscles weak			spasms		
Lumps/bumps			tremors		
Upper back pain			Stiff neck		
pain			Stiff joints		
Mid back pain			Swollen feet		
Low back pain			Knee pain		
tingling			Weak knees		
numbness			Socks leave indents?		
Early graying in family			Joint pain		
Weak teeth					

Please mark areas where you feel pain, numbness or tingling or any concerns:

Front Back



Men	occasional	frequent		occasional	frequent
Genital rash/itch			Sexual dysfunction		
Genital pain			Prostate problems		

Women	occasional	frequent		occasional	frequent
Regular period			cysts/fibroid		
Irregular period			Vaginal discharge		
Cramps (when?)			Yeast infection		
Breast tenderness			Heavy period		
PMS			Light period		

Could you be pregnant now? (circle) Yes No Number of pregnancies______________

Are you trying to get pregnant?
Live births: # miscarriages # abortions # premature births # C sections

Periods:
Age started__________ Flow (number of days):_________ Days between cycles____________
Flow (circle one) Light Medium Heavy Blood clots (circle one) No Some Many
Date last period started:____________ Age of menopause__________
Any irregular pap smears? Action taken as a result:
Frequency of PMS_______________________
PMS symptoms____________________________

Miscellaneous	occasional	frequent		occasional	frequent
Bruise easily			Skin rash		
acne			Skin lesions		
Premature gray			alcohol		
tobacco			Street drugs		

Circle any appropriate: Dry skin/ dry hair / dry eyes/ dry nails/ dry throat/ dry nose/ itching/ oily skin/ oily hair / Edema / dandruff/

Is there anything else you want me to know?