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Health History Form

Please take the time to fill this form out as thoroughly as possibly. An accurate diagnosis is dependent on the information provided here. *All of your answers will be held absolutely confidential.* If you have anything additional you wish to bring to our attention, please note it in the "comments" section on page 3. Thank you.

Name (first and last) _____ Date _____

Street _____ City _____ Zip Code _____

Phone: *(may we leave a message?)* Home _____ Cell _____

E-mail *(please print clearly)* _____

Date of Birth _____ Age _____ Height _____ Weight _____

Occupation _____

Emergency Contact: Name _____ Phone _____

Have you been treated with acupuncture or Chinese herbal medicine before? [ ] Yes [ ] No

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**Additional information here.*

Referred by: Name and/or Website _____

* *

Reason for visit: *(If there is not enough space to write feel free to use the other side.)*

What is the main reason for which you are seeking treatment? _____

_____

_____

How long ago did this problem begin? _____

To what extent does this problem interfere with your daily activities such as work, exercise, sleep, etc? _____

_____

Have you been given a diagnosis for this problem? If so, what? _____

_____

Are you on any medication for this problem? If so, what? _____

_____

What other kinds of treatment have you tried? _____

_____

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Past Medical History (Please include date)
Significant Illnesses (please circle all applicable)

Cancer	Diabetes	Hepatitis	High Blood Pressure
Heart Disease	Seizures	Stroke	Thyroid Disease

Other Diagnosis _____

Do you have a pacemaker? _____

Do you have any allergies? _____

Surgeries or Significant Traumas _____

Family Medical History (Please circle all applicable)

Asthma Cancer Diabetes High Blood Pressure Heart Disease Seizures Stroke

Other: _____

Daily Habits

Medicines taken within the past 2months _____

Do you have a regular exercise program? If so, describe: _____

_____

Do you smoke? If so, how much? _____

How much coffee, tea or soda do you drink per week? _____

How much water do you drink daily? _____

How much alcohol do you drink per day? _____

Please describe your average daily diet below:

Morning	Afternoon	Evening

Name_____ Date_____

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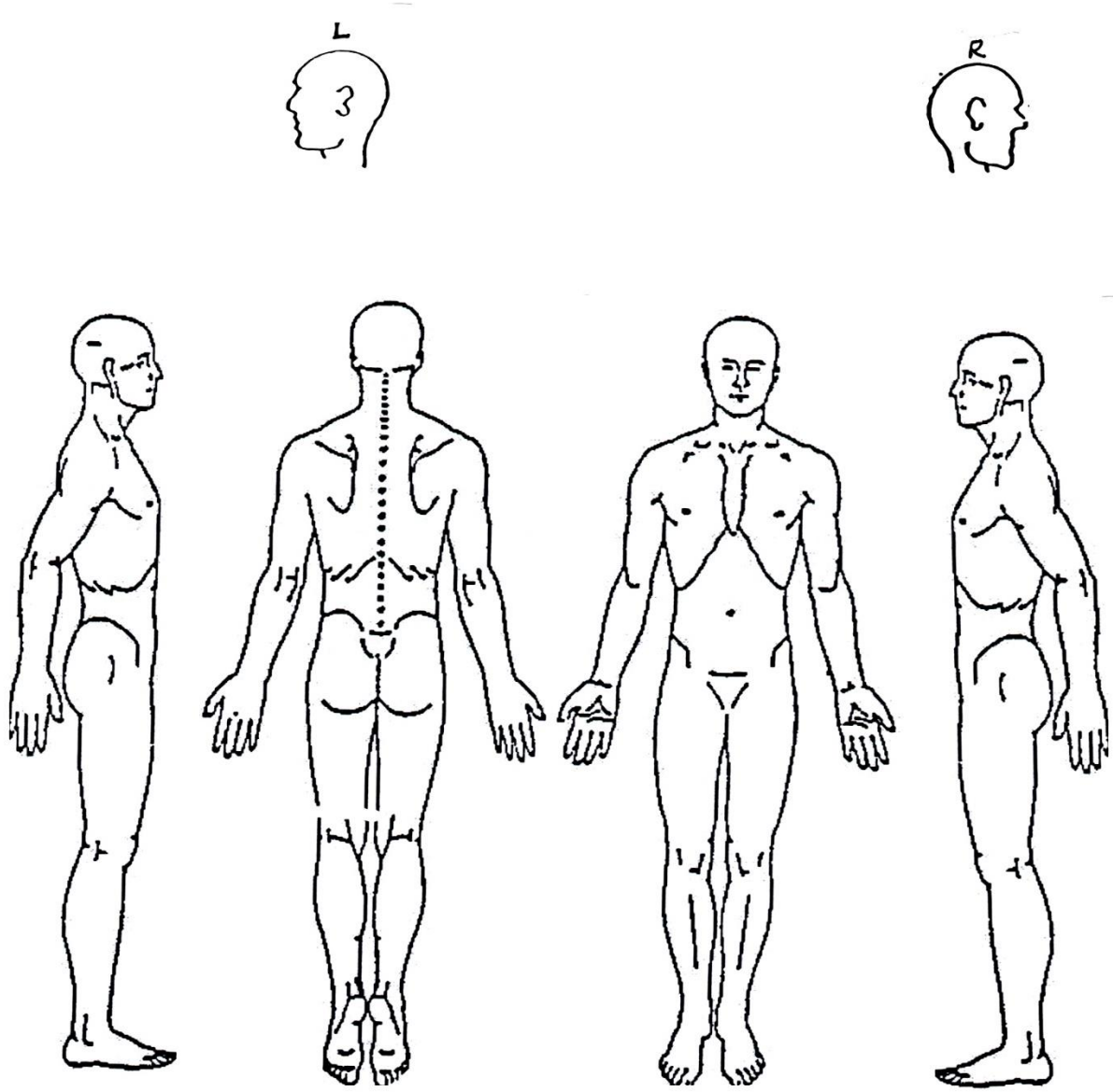
Please indicate any painful or distressed areas on the figures below.



Name _____ Date _____

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Please check if you have had *(in the last six months)*:

General

- ❑ Fevers
- ❑ Sweat easily
- ❑ Bleed or bruise easily
- ❑ Peculiar tastes or smells
- ❑ Sudden energy drop (time of day?)
- ❑ Poor sleeping
- ❑ Chills
- ❑ Weight loss
- ❑ Strong thirst (hot or cold drinks)
- ❑ Fatigue
- ❑ Night sweats
- ❑ Cravings
- ❑ Change in appetite
- ❑ Weight gain

Skin and Hair

- ❑ Rashes
- ❑ Itching
- ❑ Dandruff
- ❑ Change in hair or skin texture
- ❑ Any other hair or skin problems?
- ❑ Ulcerations
- ❑ Eczema
- ❑ Loss of hair
- ❑ Hives
- ❑ Pimples
- ❑ Recent moles

Cardiovascular

- ❑ High blood pressure
- ❑ Irregular heartbeat
- ❑ Cold hands or feet
- ❑ Blood clots
- ❑ Low blood pressure
- ❑ Difficulty in breathing
- ❑ Swelling of hands
- ❑ Phlebitis
- ❑ Chest pain
- ❑ Fainting
- ❑ Swelling of feet

Any other heart or blood vessel problems? ----------

Respiratory

- ❑ Cough
- ❑ Bronchitis
- ❑ Difficulty in breathing when lying down
- ❑ Coughing blood
- ❑ Pneumonia
- ❑ Asthma
- ❑ Pain with a deep breath
- ❑ Production of phlegm

Any other lung/breathing problems? ---------- What color? ----------

Gastrointestinal

- ❑ Nausea
- ❑ Constipation
- ❑ Black stools
- ❑ Bad breath
- ❑ Bleeding gums
- ❑ Vomiting
- ❑ Gas
- ❑ Blood in stools
- ❑ Rectal pain
- ❑ Abdominal pain or cramps
- ❑ Diarrhea
- ❑ Belching
- ❑ Indigestion
- ❑ Hemorrhoids
- ❑ Chronic laxative use

Any other problems with your stomach or intestines? ----------

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Genito-Urinary

- ❑ Pain upon urination
- ❑ Urgency to urinate
- ❑ Decrease in flow
- ❑ Do you wake up to urinate? How often? ----------
- ❑ Frequent urination
- ❑ Unable to hold urine
- ❑ Impotency
- ❑ Blood in urine
- ❑ Kidney stones
- ❑ Sores on genitals
- ❑ Any particular color to your urine?----------

Any other problems with your genital or urinary system? ----------

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Name---------- Date----------

Reproductive and Gynecologic

Are you pregnant? *[ ] Yes* *[ ] No*
Is it possible that you are pregnant? *[ ] Yes* *[ ] No*

- ❑ Pregnancies? #_____
- ❑ Live births? #_____
- ❑ Miscarriages? #_____
- ❑ Abortions? #_____
- ❑ Premature births? #_____
- ❑ Age of first menses? _____
- ❑ Period between menses
- ❑ Duration of menses
- ❑ Unusual character (heavy/light)
- ❑ Irregular periods
- ❑ Painful periods
- ❑ Clots
- ❑ Last PAP _____
- ❑ Vaginal discharge
- ❑ Vaginal sores
- ❑ Breast lumps
- ❑ Menopause: Age? _____
- ❑ Changes to body/psyche prior to menstruation _____
- ❑ Do you practice birth control? What type and for how long? _____

Muscular/Skeletal

- ❑ Neck pain
- ❑ Blood clots
- ❑ Difficulty in breathing
- ❑ Swelling of hands
- ❑ Phlebitis
- ❑ Chest pain
- ❑ Fainting
- ❑ Swelling of feet
- ❑ Any other muscular/skeletal problems? _____

NeuropSychological

- ❑ Seizures
- ❑ Areas of numbness
- ❑ Concussion
- ❑ Bad temper
- ❑ Dizziness
- ❑ Lack of coordination
- ❑ Depression
- ❑ Easily susceptible to stress
- ❑ Loss of balance
- ❑ Poor memory
- ❑ Anxiety

Have you ever been treated for emotional problems? Describe: _____

Have you ever considered or attempted suicide? _____

Any other neurological or psychological problems? _____
_____

Comments

Briefly tell me of any other problems you would like to discuss. _____
_____

What other kinds of treatment have you tried? _____

Cancellation Policy

We all know that in life unexpected things come up. If cancelling an appointment, please do so at least ***within 24 hours prior to scheduled appointment***. Because we frequently have to turn others away, the ***full price of treatment will be charged for late cancellations***.

Thank you very much for your consideration.

I agree to pay the full treatment fee if I cancel within 24 hours.

Signature _____ **Date** _____