HEALTH HISTORY

Date: ____ / ____ / ______

Name:				Sex:	Age:
Address:		City:		State:	Zip Code:
Phone #1: Home Cell Other	Phone #2: Work Cell Other		Email:		
Date of Birth:	Emergency Contact: *(name & relationship)*		Phone #:		
Height:	Weight:	Relationship Status:			
Occupation:		Employer:			
How did you hear of our clinic?:			Referred by:		
Physician:	Phone #:		Have you been treated by Acupuncture or Oriental Medicine Before?		

MAIN COMPLAINTS

Please write in your top 3 health complaints / concerns in order of importance to you. Circle the items that make it better or worse and mark on the scale from 1-10 the severity of the condition (1=no symptoms, 10=worst ever)

1 ______________________________

When did this start? __________________ago

Heat makes it:	better	no change	worse
Cold makes it:	better	no change	worse
Damp weather:	better	no change	worse
Exercise / Activity:	better	no change	worse

1 |――――――|――――――| 10

2 ______________________________

When did this start? __________________ago

Heat makes it:	better	no change	worse
Cold makes it:	better	no change	worse
Damp weather:	better	no change	worse
Exercise / Activity:	better	no change	worse

1 |――――――|――――――| 10

3 ______________________________

When did this start? __________________ago

Heat makes it:	better	no change	worse
Cold makes it:	better	no change	worse
Damp weather:	better	no change	worse
Exercise / Activity:	better	no change	worse

1 |――――――|――――――| 10

HEALTH HISTORY

Circle the (person) if you have / had the condition and note the year it started.
Circle the (family) if there is a family history of the condition.

	YOU	Year	FAMILY
Cancer *type(s)?* ______________		_______	
Diabetes		_______	
Hepatitis		_______	
High Blood Pressure		_______	
Heart Disease		_______	
Stroke		_______	
Seizure Disorder		_______	
Thyroid Disease		_______	
Asthma		_______	
Pacemaker			

	YOU	Year	FAMILY
Osteoporosis		_______	
Herpes		_______	
AIDS / HIV		_______	
Other STD		_______	
Rheumatic Fever		_______	
Alcoholism		_______	
Allergies *type(s)?* ______________		_______	
Mental Illness		_______	
Kidney Disease		_______	
Anemia		_______	

HABITS

	Amount / Week	If Quit, Year?
Coffee / Tea	____________	_______
Soda	____________	_______
Tobacco	____________	_______
Alcohol	____________	_______
Drugs	____________	_______

EXERCISE

Do you exercise regularly? ☐ Yes ☐ No

If so, what and how often:

____

____

____

DIET

Do you have a special diet now or in the past? (vegetarian, vegan, raw, Atkins, etc.)

Describe w/ dates:

MEDICATIONS

Please note what medications, herbs or supplements that you take regularly

____

____

____

INJURIES & SURGERIES

Please note what happened to what body area and when it occurred (incl. dental)

____

____

____

TEMPERATURE

How warm / cold you feel (not in degrees); relative to other people do you wear more or less layers, etc.

COLD |————|————| HOT

- ☐ Cold hands or feet
- ☐ Chills
- ☐ Cold "in the bones"
- ☐ Areas of numbness

Thirst for cold / hot drinks
- ☐ Thirst, no desire to drink
- ☐ Absence of thirst
- ☐ Excessive thirst

- ☐ Night sweats
- ☐ Unusual sweats

When_______am / pm
Where on body_________

- ☐ Hot hands, feet, chest
- ☐ Hot flashes
- ☐ Hot in afternoon
- ☐ Hot at night

MOISTURE

Your overall body moisture (hair, skin, mouth, bowels, etc.)

DRY |————|————| OILY

- ☐ Dry skin
- ☐ Dry hair
- ☐ Dry eyes
- ☐ Dry brittle nails

- ☐ Dry mouth
- ☐ Dry lips
- ☐ Dry throat
- ☐ Dry nose / Nosebleeds

- ☐ Edema / Swelling Where on your body?:
- ☐ Rashes ____________________
- ☐ Itching ____________________
- ☐ Dandruff

- ☐ Oily skin
- ☐ Oily hair
- ☐ Pimples
- ☐ Weight gain / loss

DIGESTION

DIARRHEA |————|————| CONSTIPATION

BM: How often? _____x / every _____days

Stools keep shape? ☐ Y ☐ N
- ☐ Alternating diarrhea & constipation (IBS)
- ☐ Indigestion

- ☐ Gas
- ☐ Bloating
- ☐ Belching
- ☐ Poor appetite

- ☐ Nausea / Vomiting
- ☐ Bad breath
- ☐ Heartburn
- ☐ Excessive hunger

- ☐ Dry Stools
- ☐ Difficult to pass
- ☐ Tired after BM
- ☐ Foul smelling stools

ENERGY

LOW |————|————| HIGH

- ☐ Sudden energy drop

Time of day: _____ am / pm
- ☐ Energy drop after eating
- ☐ Fatigue

- ☐ Dependence on caffeine / stimulants
- ☐ Wired / ungrounded feeling
- ☐ Body / Limbs feel heavy
- ☐ Body / Limbs feel weak

- ☐ Shortness of breath
- ☐ Heart Palpitations
- ☐ Blood pressure High / Low
- ☐ Bleed / Bruise easy

- ☐ Hard to concentrate
- ☐ Poor memory
- ☐ Dizziness / lightheaded
- ☐ Headaches _____x / week

SLEEP

hours per night ______
- ☐ Difficulty falling asleep
- ☐ Wake ___x/ night @_____am / pm
- ☐ Wake to urinate *How often?_______*
- ☐ Disturbing dreams
- ☐ Restless sleep
- ☐ Not rested upon waking

EMOTIONS

What emotion(s) dominate your experience?

- ☐ Anger
- ☐ Irritability
- ☐ Anxiety
- ☐ Worry
- ☐ Obsessive thinking
- ☐ Sadness
- ☐ Grief
- ☐ Depression
- ☐ Joy
- ☐ Fear
- ☐ Timid / shy
- ☐ Indecision

EYES, EARS NOSE THROAT

- ☐ Poor vision
- ☐ Night blindness
- ☐ Red eyes
- ☐ Itchy eyes
- ☐ Spots in front of eyes
- ☐ Sinus congestion
- ☐ Phlegm (*color*_______)
- ☐ Poor hearing
- ☐ Ringing in ears
- ☐ Excess earwax
- ☐ Sore throat
- ☐ Dental problems
- ☐ Mouth sores
- ☐ Cough

URINARY

Fluid in = fluid out? ☐ Y ☐ N
- ☐ Decrease in flow
- ☐ Dribbling
- ☐ Difficulty starting / stopping
- ☐ Incontinence
- ☐ Kidney stones
- ☐ Urgency to urinate
- ☐ Frequent urination
- ☐ Pain on urination
- ☐ Burning sensation
- ☐ Cloudy urine
- ☐ Blood in urine

REPRODUCTIVE

Are you sexually active? ☐ Y ☐ N
- ☐ Change of sexual drive: ⇧ ⇩
- ☐ Erectile dysfunction
- ☐ Premature ejaculation
- ☐ Sores on genitals
- ☐ Discharge
- ☐ Prostate disease
- ☐ Genital Pain
- ☐ Jock Itch
- ☐ Vasectomy
- ☐ Hernia
- ☐ Hemorrhoids

WOMEN ONLY

MENSES

Age at first menses: ______
Length of full cycle: ______ days
Length of menses: ____ days
Last menses start date: ____ / ____
# of pregnancies: ____
# of births: ____ premature ____
# of abortions / miscarriages: ____

- ☐ Heavy periods
- ☐ Light periods
- ☐ Painful periods
- ☐ Irregular periods
- ☐ Clots
- ☐ Cramps
  - ☐ Before bleeding
  - ☐ First day
  - ☐ During period

- ☐ Breast tenderness
- ☐ Changes in body/psyche prior to menstruation (PMS)
- ☐ Mood changes
- ☐ Fatigue w/ menses
- ☐ Digestive changes w/ menses
- ☐ Midcycle spotting
- ☐ Yeast infections
- ☐ Birth control pill (hormonal)

MENOPAUSE

Age at last menses : ________
Year changes began: _______
- ☐ Hot flashes _____x / day
- ☐ Night sweats _____x / week
- ☐ Vaginal dryness
- ☐ Loss of sex drive