

HEALTH HISTORY

Date: ___ / ___ / ___

Name:				Sex:		Age:	
Address:				City:		State:	
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 **↑** if you have / had the condition and note the year it started.
Circle the **↑↑↑** if there is a family history of the condition.

	YOU	Year	FAMILY		YOU	Year	FAMILY
Cancer type(s)?	↑ _____		↑↑↑	Osteoporosis	↑ _____		↑↑↑
Diabetes	↑ _____		↑↑↑	Herpes	↑ _____		↑↑↑
Hepatitis	↑ _____		↑↑↑	AIDS / HIV	↑ _____		↑↑↑
High Blood Pressure	↑ _____		↑↑↑	Other STD	↑ _____		↑↑↑
Heart Disease	↑ _____		↑↑↑	Rheumatic Fever	↑ _____		↑↑↑
Stroke	↑ _____		↑↑↑	Alcoholism	↑ _____		↑↑↑
Seizure Disorder	↑ _____		↑↑↑	Allergies type(s)?	↑ _____		↑↑↑
Thyroid Disease	↑ _____		↑↑↑	Mental Illness	↑ _____		↑↑↑
Asthma	↑ _____		↑↑↑	Kidney Disease	↑ _____		↑↑↑
Pacemaker	↑ _____		↑↑↑	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

- 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

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

MOISTURE

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

DRY

- 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

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

DIGESTION

DIARRHEA

- 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

CONSTIPATION

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

ENERGY

LOW

- 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

HIGH

- 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: \uparrow \downarrow
- 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