

Patient Health History - Acupuncture, Massage & Wellness

Patients Name (Print) _____ Date of Birth _____ Age _____ M F Today's Date _____

Address _____ Phone(s) - cell, work, home (please provide 2) _____

Primary Care Physician _____ Date of last Visit _____ Phone _____
 Married Single Divorced Widowed
 Separated

Occupation _____

Client Email _____ Emergency Contact (Name/Relationship/Phone) _____

How did you hear about us? _____ Can we mail to this address? (greetings, discounts etc.) Y N

What is your Major Complaint? Are you Currently Receiving Treatment for this? Y N

MEDICATIONS: list medications you are currently taking both prescription and herbal

Medication	dosage	times taken daily	Medication	dosage	times taken daily

ALLERGIES:

HOSPITALIZATIONS - SURGERIES - SERIOUS ILLNESS: list date of occurrence and outcome

HEALTH HABITS: check for use & describe how much

Tobacco _____
 Illicit Drugs _____
 Alcohol _____
 Caffeine _____
 Exercise _____

OCCUPATIONAL EXPOSURE: check if applicable

High Stress Extreme Temperatures
 Loud Noise Hazardous Materials
 Heavy Lifting Irregular Shift Hours
 Other: _____

SIGNIFICANT ILLNESSES: please check all that apply

Bleeding Disorder <input type="checkbox"/>	Hepatitis <input type="checkbox"/>	Thyroid Disease <input type="checkbox"/>	Hypertension <input type="checkbox"/>
Heart Disease <input type="checkbox"/>	Asthma <input type="checkbox"/>	Autoimmune Disease <input type="checkbox"/>	Arthritis <input type="checkbox"/>
Psychiatric Disorder <input type="checkbox"/>	Diabetes <input type="checkbox"/>	Venereal Disease <input type="checkbox"/>	Cancer <input type="checkbox"/>
Kidney Disease <input type="checkbox"/>	Seizures <input type="checkbox"/>	Epilepsy <input type="checkbox"/>	AIDS/HIV <input type="checkbox"/>

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SYMPTOMS/ CONDITIONS: *please check any symptoms you currently have or have had in the past year*

General			Connective Tissue Dis.	<input type="checkbox"/>	Rapid Weight Change	<input type="checkbox"/>	Allergies	<input type="checkbox"/>
Dizziness	<input type="checkbox"/>	Lung Disease	<input type="checkbox"/>	Aversion to Heat	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	
Low Energy/ Fatigue	<input type="checkbox"/>	Numbness	<input type="checkbox"/>	Aversion to Cold	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	
Depression	<input type="checkbox"/>	Abnormal Sweating	<input type="checkbox"/>	Nervousness	<input type="checkbox"/>	Insomnia	<input type="checkbox"/>	
Pacemaker	<input type="checkbox"/>	Eating Disorder	<input type="checkbox"/>	Multiple Sclerosis	<input type="checkbox"/>	Infection	<input type="checkbox"/>	
Pneumonia	<input type="checkbox"/>	Chronic Fatigue	<input type="checkbox"/>	Fibromialgia	<input type="checkbox"/>	Hernia	<input type="checkbox"/>	
Loss of Memory	<input type="checkbox"/>	Poor Concentration	<input type="checkbox"/>	Lung Disease	<input type="checkbox"/>	Vomiting	<input type="checkbox"/>	

Head & Neck & ENT			Headaches	<input type="checkbox"/>	ringing Ears/Tinnitus	<input type="checkbox"/>	Ear Infection	<input type="checkbox"/>
Bleeding Gums	<input type="checkbox"/>	Migraines	<input type="checkbox"/>	Loss of Hearing	<input type="checkbox"/>	Sinus Problems	<input type="checkbox"/>	
Nosebleeds	<input type="checkbox"/>	Vision - Halos	<input type="checkbox"/>	Persistent Cough	<input type="checkbox"/>	Hayfever	<input type="checkbox"/>	
Difficult Swallow/Chew	<input type="checkbox"/>	Vision-Flashes	<input type="checkbox"/>	Heavyness in Head	<input type="checkbox"/>	Hoarseness	<input type="checkbox"/>	
Sores on Lips	<input type="checkbox"/>	Double Vision	<input type="checkbox"/>	Runny/Stuffy Nose	<input type="checkbox"/>	Phlegmy Throat	<input type="checkbox"/>	
Sores on Tongue	<input type="checkbox"/>	Red/Inflamed Eye(s)	<input type="checkbox"/>	Loss of Smell	<input type="checkbox"/>	Swollen Throat	<input type="checkbox"/>	
Sores in Mouth	<input type="checkbox"/>	Blurred Vision	<input type="checkbox"/>	Taste Change	<input type="checkbox"/>	Painful Throat	<input type="checkbox"/>	
Teeth Problems	<input type="checkbox"/>	Cataract	<input type="checkbox"/>	Corrective Vision	<input type="checkbox"/>	Hearing Aid	<input type="checkbox"/>	

Gastrointestinal			Poor Appetite	<input type="checkbox"/>	Stomach Ulcer	<input type="checkbox"/>	Belching	<input type="checkbox"/>
Abdominal Pain	<input type="checkbox"/>	Diarrhea/ Loose Stools	<input type="checkbox"/>	Borborygmus	<input type="checkbox"/>	Excess Gas	<input type="checkbox"/>	
Abdominal Bloating	<input type="checkbox"/>	Constipation	<input type="checkbox"/>	Excessive Hunger	<input type="checkbox"/>	Nausea	<input type="checkbox"/>	
Hypochondriac Pain	<input type="checkbox"/>	Black Stools	<input type="checkbox"/>	Excessive Thirst	<input type="checkbox"/>	Indigestion	<input type="checkbox"/>	
Stomachache	<input type="checkbox"/>	White Stools	<input type="checkbox"/>	Irritable Bowel Syndr.	<input type="checkbox"/>	Food Allergies	<input type="checkbox"/>	
Vomiting Blood	<input type="checkbox"/>	Difficulty Swallowing	<input type="checkbox"/>	Nervous Vomiting	<input type="checkbox"/>	Malnutrition	<input type="checkbox"/>	
Bloody Stools	<input type="checkbox"/>	Hemorrhoids	<input type="checkbox"/>	Ulcerative Colitis	<input type="checkbox"/>	Rectal Bleeding	<input type="checkbox"/>	
Blood in Urine	<input type="checkbox"/>	Heartburn/ Acid Reflux	<input type="checkbox"/>	Anorexia Nervosa	<input type="checkbox"/>	Bulimia	<input type="checkbox"/>	

Skin			Eczema	<input type="checkbox"/>	Sore that won't Heal	<input type="checkbox"/>	Itching	<input type="checkbox"/>
Acne	<input type="checkbox"/>	Bruise Easily	<input type="checkbox"/>	Irregular Scars	<input type="checkbox"/>	Discoloration	<input type="checkbox"/>	
Lumps	<input type="checkbox"/>	Moles, Warts, Lesions	<input type="checkbox"/>	Excessive Dryness	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	

Muscle/Joint/Bone: P=Pain, N=Numbness, W=Weakness				Arms	<input type="checkbox"/>	Fingers	<input type="checkbox"/>	Hips	<input type="checkbox"/>
Back	<input type="checkbox"/>	Legs	<input type="checkbox"/>	Feet	<input type="checkbox"/>	Neck	<input type="checkbox"/>	Shoulders	<input type="checkbox"/>
								Other	<input type="checkbox"/>

Cardiovascular			High Blood Pressure	<input type="checkbox"/>	Arteriosclerosis	<input type="checkbox"/>	Varicose Veins	<input type="checkbox"/>
Chest Pain	<input type="checkbox"/>	Low Blood Pressure	<input type="checkbox"/>	Arythmia	<input type="checkbox"/>	Poor Circulation	<input type="checkbox"/>	
Palpitations	<input type="checkbox"/>	High Cholesterol	<input type="checkbox"/>	Irregular Heart Beat	<input type="checkbox"/>	Edema	<input type="checkbox"/>	

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Respiratory		Pneumothorax	<input type="checkbox"/>	Hayfever	<input type="checkbox"/>	COPD	<input type="checkbox"/>
Pneumonia	<input type="checkbox"/>	Shortness of Breath	<input type="checkbox"/>	Recurrent Bronchitis	<input type="checkbox"/>	Asthma	<input type="checkbox"/>
Difficulty Breathing	<input type="checkbox"/>	Persistent Cough	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>

Genitourinary		Bloody Urine	<input type="checkbox"/>	Poor Bladder Control	<input type="checkbox"/>	Dark Urine	<input type="checkbox"/>
Dilute Urine	<input type="checkbox"/>	Cloudy Urine	<input type="checkbox"/>	Frequent Urine	<input type="checkbox"/>	Scanty Urine	<input type="checkbox"/>
Need Catheter	<input type="checkbox"/>	Painful Urination	<input type="checkbox"/>	Urgency to Urinate	<input type="checkbox"/>	Profuse Urine	<input type="checkbox"/>

Neurologic		Fainting	<input type="checkbox"/>	Convulsions	<input type="checkbox"/>	Paralysis	<input type="checkbox"/>
Handwriting Change	<input type="checkbox"/>	Speech Change	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	Tremor/ Ticks	<input type="checkbox"/>
Recent Clumsiness	<input type="checkbox"/>	Involuntary Movement	<input type="checkbox"/>	Numbness	<input type="checkbox"/>	Vertigo	<input type="checkbox"/>
Slow Reflexes	<input type="checkbox"/>	Drowsiness	<input type="checkbox"/>	Bells Palsy	<input type="checkbox"/>	Drowsiness	<input type="checkbox"/>

Emotional		Easily Irritable	<input type="checkbox"/>	Easily Angered	<input type="checkbox"/>	Depressed	<input type="checkbox"/>
Cry Uncontrollably	<input type="checkbox"/>	Fearful	<input type="checkbox"/>	Manic	<input type="checkbox"/>	Anxious	<input type="checkbox"/>
Troubled Dreams	<input type="checkbox"/>	Difficult Expressing Self	<input type="checkbox"/>	Terrors	<input type="checkbox"/>	Bi-Polar	<input type="checkbox"/>
ADD	<input type="checkbox"/>	Panic Attacks	<input type="checkbox"/>	Other (please explain)	<input type="checkbox"/>		<input type="checkbox"/>

Weight/ Diet/ Lifestyle		Underweight	<input type="checkbox"/>	Overweight	<input type="checkbox"/>	Vegetarian	<input type="checkbox"/>
Healthy Diet	<input type="checkbox"/>	Exercise Regularly	<input type="checkbox"/>	Exercise Excessively	<input type="checkbox"/>	No Exercise	<input type="checkbox"/>
Take Steroids	<input type="checkbox"/>	Special Diet	<input type="checkbox"/>	Unhealthy Diet	<input type="checkbox"/>	other	<input type="checkbox"/>

Women Only		Abnormal Pap Smear	<input type="checkbox"/>	Bleed btw Periods	<input type="checkbox"/>	Heavy Periods	<input type="checkbox"/>
Irregular Periods	<input type="checkbox"/>	Endometriosis	<input type="checkbox"/>	Cystic Fibrosis	<input type="checkbox"/>	Painful Periods	<input type="checkbox"/>
Breast Lumps	<input type="checkbox"/>	Premenstrual Tension	<input type="checkbox"/>	Moodiness	<input type="checkbox"/>	Contraceptives	<input type="checkbox"/>
Uterine Prolapse	<input type="checkbox"/>	Pain with Intercourse	<input type="checkbox"/>	Scanty Periods	<input type="checkbox"/>	Facial Hair	<input type="checkbox"/>
Sores on Genitalia	<input type="checkbox"/>	Yeast Infection	<input type="checkbox"/>	Vaginal Discharge	<input type="checkbox"/>	Hysterectomy	<input type="checkbox"/>
Low Sexual Energy	<input type="checkbox"/>	Menopausal	<input type="checkbox"/>	Venereal Disease	<input type="checkbox"/>	Dryness	<input type="checkbox"/>
<i>Please list # of Pregnancies with dates, Miscarriages, date of last menstrual period and last pap smear</i>		Abortion	<input type="checkbox"/>	<25 day Cycle	<input type="checkbox"/>	>35 day Cycle	<input type="checkbox"/>
May be Pregnant	<input type="checkbox"/>						

Men Only		Genital Pain	<input type="checkbox"/>	Penis Discharge	<input type="checkbox"/>	Impotence	<input type="checkbox"/>
Excess Sexual Energy	<input type="checkbox"/>	Genital Sores	<input type="checkbox"/>	Enlarged Prostate	<input type="checkbox"/>	Hernia	<input type="checkbox"/>
Low Sexual Energy	<input type="checkbox"/>	Lump in Testicles	<input type="checkbox"/>	Nocturnal Emissions	<input type="checkbox"/>	Infertility	<input type="checkbox"/>

Patients Signature _____

Date _____

Signature of Guardian _____

Date _____