Print Form

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Acupuncture and Herbal Medicine
PATIENT HEALTH HISTORY

PATIENT INFORMATION

Name: _____ Date: _____

Address: _____ City: _____ Zip: _____

Cell Phone: _____ Home Phone: _____ Email: _____

Occupation: _____ Employer: _____

Date of birth: ___ / ___ / _____ Age: _____ Sex: ◯Female ◯Male

Emergency contact: _____ Relationship: _____ Phone: _____

Primary care physician: _____ Phone: _____ Fax: _____

Address: _____ City: _____

Referred by: _____

What is the best way to contact you? ◯Phone ◯Email ◯Text Would you like an appointment confirmation? ◯Yes ◯No

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PERSONAL HISTORY **What are your primary health concerns?**

A: _____ Onset: _____

Describe what caused it or how it started: _____

_____

How does this condition affect you? _____

Have you received treatment for this condition? ◯Yes ◯No If so, when? _____

What type of treatment? _____

From whom? _____ Diagnosis? _____

Results of treatment: _____

What makes the symptoms worse? _____ Better? _____

B: _____ Onset: _____

Describe what caused it or how it started: _____

_____

How does this condition affect you? _____

Have you received treatment for this condition? ◯Yes ◯No If so, when? _____

What type of treatment? _____

From whom? _____ Diagnosis? _____

Results of treatment: _____

What makes the symptoms worse? _____ Better? _____

C: _____ Onset: _____

Describe what caused it or how it started: _____

_____

How does this condition affect you? _____

Have you received treatment for this condition? ◯ Yes ◯ No If so, when? _____

What type of treatment? _____

From whom? _____ Diagnosis? _____

Results of treatment: _____

What makes the symptoms worse? _____ Better? _____

MEDICAL HISTORY [Please include month/year (XX/XXXX) when the diagnosis was established]

Check all conditions that apply:

_____ Anemia	_____ Heart disease or stroke	_____ Neuromuscular disease
_____ Arthritis ◯ RA ◯ OA	_____ Hepatitis	_____ Osteoporosis
_____ Breathing problems	_____ High blood pressure	_____ Psychological challenges
_____ Cancer	_____ High Cholesterol	_____ Seizures
_____ Diabetes mellitus	_____ HIV/AIDS positive	_____ Thyroid disease
_____ Digestive disorders	_____ Kidney disease	_____ Tuberculosis
_____ Fibromyalgia	_____ Lung/pulmonary disease	_____ Ulcer
_____ Gallbladder disease	_____ Metabolic syndrome	_____ Venereal disease

Other conditions: _____

Please put a check next to conditions that you have experienced in the last three months

GERERAL:

☐ Bleed or bruise easily	☐ Insomnia	☐ Strong Thirst
☐ Changes in appetite	☐ Localized weakness	☐ Sweating easily
☐ Chills	☐ Night sweats	☐ Tremors
☐ Cravings	☐ Poor appetite	☐ Weight gain
☐ Disturbed sleep	☐ Poor balance	☐ Weight loss
☐ Fever	☐ Sudden energy drop (time of day?) _____	

☐ Other unusual or abnormal conditions you have noticed in your general sense of health? _____

SKIN & HAIR:

☐ Dandruff	☐ Hives	☐ Rashes
☐ Eczema	☐ Itching	☐ Recent moles
☐ Hair loss	☐ Pimples	☐ Ulcerations

☐ Changes in hair or skin texture? _____

Any other hair or skin problems? _____

HEAD, EYES, EARS, NOSE, THROAT:

☐ Blurry vision	☐ Facial pain	☐ Poor hearing
☐ Cataracts	☐ Glasses	☐ Poor vision
☐ Color blindness	☐ Grinding teeth	☐ Recurrent sore throat
☐ Concussions	☐ Headaches	☐ Ringing in ears
☐ Dizziness	☐ Jaw clicks	☐ Sinus problems
☐ Earaches	☐ Migraines	☐ Spots in front of eyes
☐ Eye pain	☐ Night blindness	☐ Sores on lips/tongue
☐ Eyestrain	☐ Nose bleeds	☐ Teeth problems

Any other head or neck problems? _____

CARDIOVASCULAR:

- ☐ Blood clots
- ☐ Chest pain
- ☐ Cold hands/feet
- ☐ Difficulty breathing
- ☐ Dizziness
- ☐ Fainting
- ☐ High blood pressure
- ☐ Irregular heartbeat
- ☐ Low blood pressure
- ☐ Phlebitis or deep vein thrombosis
- ☐ Swelling of hands
- ☐ Swelling of feet

Any other heart, chest, or blood vessel problems? _____

RESPIRATORY:

- ☐ Difficulty breathing when lying down
- ☐ Asthma (more difficulty breathing) ◯ In or ◯ Out
- ☐ Bronchitis
- ☐ Cough
- ☐ Coughing up blood
- ☐ Pain with deep inhalation
- ☐ Pneumonia
- ☐ Production of phlegm (color)

Any other lung or breathing problems? _____

GASTROINTESTINAL:

- ☐ Abdominal pain/cramps
- ☐ Bad breath
- ☐ Belching
- ☐ Black stools
- ☐ Blood in stools
- ☐ Chronic laxative use
- ☐ Constipation
- ☐ Diarrhea
- ☐ Gas
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Nausea
- ☐ Rectal pain
- ☐ Vomiting

Any other problems with stomach or intestines? _____

GENITO-URINARY:

- ☐ Blood in urine
- ☐ Decease in flow
- ☐ Frequent urination
- ☐ Impotence
- ☐ Kidney stones
- ☐ Pain with urination
- ☐ Sores on genitals
- ☐ Unable to hold urine
- ☐ Urgency to urinate

Do you wake up at night to urinate? ◯ Yes ◯ No ☐ Any color in urine: _____

Any other problems with your genital/urinary function? _____

REPRODUCTIVE & GYNECOLOGIC:

- ☐ Irregular menses
- ☐ Menopause (Age at 1 year past last menses)
- ☐ Changes in body/psyche prior to menstruation: _____ Duration: _____
- ☐ Menstrual clots
- ☐ Painful menses
- ☐ Unusual menses

Other problems? _____

Age at 1st menses: _____ Days between menses: _____ # Days bleeding: _____

1st day of last menses: _____ # Pregnancies: _____ # Births: _____

Miscarriages: _____ Premature births: _____ Abortions: _____

Birth control: ◯ Yes ◯ No Type: _____ How long: _____

Date of last PAP: _____ Date of last mammogram: _____

MUSCULOSKELETAL:

- ☐ Foot or ankle pain
- ☐ Hand/wrist pain
- ☐ Hip pain
- ☐ Knee pain
- ☐ Lower back pain
- ☐ Mid back pain
- ☐ Muscle spasm
- ☐ Muscle weakness
- ☐ Neck pain
- ☐ Shoulder pain
- ☐ Upper back pain
- ☐ Other region: _____

Any other joint or bone problems? _____

NEUROPSYCHOLOGICAL:

- ☐ Anxiety
- ☐ Area of numbness
- ☐ Bad temper
- ☐ Concussion
- ☐ Depression
- ☐ Dizziness
- ☐ Easily susceptible to stress
- ☐ Lack of coordination
- ☐ Loss of balance
- ☐ Mood swings
- ☐ Poor memory
- ☐ Seizures

Any other neurological or psychological problems? _____

LIFESTYLE:

Daily exercise? _____

How long do you normally sleep? _____ Are you rested in the morning? ◯ Yes ◯ No

Do you have difficulties with: ☐ Falling asleep ☐ Staying asleep ☐ Dream disturbed sleep

How is your energy level? _____ When is it the highest? _____ When is it the lowest? _____

Height: _____ Weight: _____ Last blood pressure reading? _____

Please describe your average daily diet:

Breakfast: _____

Lunch: _____

Dinner: _____

Snack: _____

Water intake: _____

Allergies/Sensitivities: _____

Do you smoke cigarettes? ◯ Yes ◯ No # Packs _____ # Years _____

Do you drink ☐ Coffee ☐ Tea ☐ Carbonated beverages ☐ Alcholic beverages, please specify: _____

Do you smoke marijuana or use recreational drugs? ◯ Yes ◯ No Specify: _____

Prescription medications taken within the last two months: _____

_____ _____

_____ _____

Over-the-counter medications taken within the last two months: _____

Herbal supplements: _____

Homeopathic remedies: _____

Vitamins or minerals: _____

Creams, liniments, external preparations: _____

ACCIDENTS, HOSPITALIZATION, SURGERIES: (Please give date and description of incident or procedure)

_____

_____

FAMILY MEDICAL HISTORY: (Please specify family member)

_____	Alcoholism or Drug Abuse	_____	Depression	_____	Hypertension
_____	Asthma	_____	Diabetes	_____	Stroke
_____	Auto-Immune disease	_____	Mental Illness	_____	Thyroid
_____	Cancer	_____	Heart disease		

Other (specify) _____

Do you have other health concerns not listed that came to mind when answering these questions?

_____

What are you treatment goals, hopes, and expectations? _____

_____

Do you have any concerns about treatment? _____