

CONFIDENTIAL HEALTH HISTORY FORM

Date: _____

Name: _____

Address: _____

Birthdate: _____

Gender: _____

Home phone: _____ Work/other phone: _____

Relationship status: _____

Email (optional): _____

Height: _____

Emergency contact name: _____
& phone #: _____

Weight: _____

Referred by: _____ Occupation: _____

Reason for visit: _____ Have you had acupuncture before?
Chinese herbal medicine?

How long have you had this condition?

Are you currently under the care of a physician?

If yes, what for?

Name of physician: _____

Physician phone #: _____

Other concurrent therapies: _____

FAMILY MEDICAL HISTORY

- Allergies _____
- Arteriosclerosis _____
- Cancer _____
- Diabetes _____
- Seizures _____
- Asthma _____
- Heart Disease _____
- Stroke _____
- Alcohol/Drug Addiction _____
- High Blood Pressure _____

PERSONAL MEDICAL HISTORY (check all current or past conditions)

- AIDS/HIV Alcohol/Drug
- Cancer
- Heart disease
- Pleurisy
- Thyroid disorder
- Addiction
- Chicken pox
- Hepatitis
- Pneumonia
- Tuberculosis
- Allergies
- Diabetes
- Herpes
- Polio
- Typhoid fever
- Appendicitis
- Emphysema
- High blood pressure
- Rheumatic fever
- Ulcer
- Arteriosclerosis
- Epilepsy
- Measles
- Scarlet fever
- Venereal disease
- Asthma
- Goiter
- Multiple sclerosis
- Seizures
- Whooping cough
- Birth trauma
- Gout
- Mumps
- Stroke
- Other

Major traumas/accidents & dates:

Surgeries & dates:

Current Medications and Supplements & dosages: (attach separate sheet if necessary)

- Appetite Low coffee artificial sugar glasses water/day
- Med. Soft drinks sweetener salty food _____
- High

Breakfast	Snack	Lunch	Snack	Dinner	Snack
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Lifestyle

- Alcohol Other
- Tobacco Recreational drugs
- Marijuana Stress
- Occupational hazards
- Exercise:** Type & frequency _____

Check all that apply, and indicate "P" for previously

General Symptoms

- | | | | | |
|--|--|--|--|--|
| <input type="checkbox"/> Poor appetite | <input type="checkbox"/> Recent weight loss/gain | <input type="checkbox"/> Lack of strength | <input type="checkbox"/> Fever | <input type="checkbox"/> Vertigo/dizziness |
| <input type="checkbox"/> Heavy appetite | <input type="checkbox"/> Poor sleep | <input type="checkbox"/> Bodily heaviness | <input type="checkbox"/> Chills | <input type="checkbox"/> Bleed/bruise easily |
| <input type="checkbox"/> Strong desire hot drinks | <input type="checkbox"/> Heavy sleep | <input type="checkbox"/> Cold hands/feet | <input type="checkbox"/> Night sweats | <input type="checkbox"/> Unusual taste (describe)
_____ |
| <input type="checkbox"/> Strong desire cold drinks | <input type="checkbox"/> Dream-disturbed sleep | <input type="checkbox"/> Poor circulation | <input type="checkbox"/> Sweat easily | |
| | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Muscle cramps | |

Head/Neck

- | | | | | |
|--|---|---|---|--|
| <input type="checkbox"/> Glasses | <input type="checkbox"/> Cataracts | <input type="checkbox"/> Excessive saliva | <input type="checkbox"/> Lumps in throat | <input type="checkbox"/> Earaches |
| <input type="checkbox"/> Eye strain/pain | <input type="checkbox"/> Teeth problems | <input type="checkbox"/> Sinus problems | <input type="checkbox"/> Thyroid problems | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Red/itchy eyes | <input type="checkbox"/> Gum problems | <input type="checkbox"/> Excessive phlegm | _____ | <input type="checkbox"/> Concussions |
| <input type="checkbox"/> Spots in eyes | <input type="checkbox"/> TMJ | Color/texture: _____ | <input type="checkbox"/> Nose bleeds | <input type="checkbox"/> Other:
_____ |
| <input type="checkbox"/> Poor vision | <input type="checkbox"/> Facial pain | <input type="checkbox"/> Sore throat | <input type="checkbox"/> Ringing in ears | |
| <input type="checkbox"/> Night blindness | <input type="checkbox"/> Sores on lips/tongue | <input type="checkbox"/> Swollen glands | <input type="checkbox"/> Poor hearing | |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Dry mouth | | <input type="checkbox"/> Hearing aid | |

Respiratory

- | | | | |
|---|---|--|---|
| <input type="checkbox"/> Difficulty breathing | <input type="checkbox"/> Asthma/wheezing | Color of phlegm _____ | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Cough | <input type="checkbox"/> Coughing up blood | <input type="checkbox"/> Other
_____ |
| <input type="checkbox"/> Chest tightness | <input type="checkbox"/> Wet <input type="checkbox"/> Dry | | |

Cardiovascular

- | | | | |
|---|--|---|---|
| <input type="checkbox"/> High blood pressure
Average reading _____ | <input type="checkbox"/> Blood clots | <input type="checkbox"/> Heart palpitations | <input type="checkbox"/> Varicose veins |
| <input type="checkbox"/> Low blood pressure
Average reading _____ | <input type="checkbox"/> Fainting | <input type="checkbox"/> Irregular heartbeat | <input type="checkbox"/> Other
_____ |
| | <input type="checkbox"/> Chest pain | <input type="checkbox"/> Phlebitis (inflammation of vein) | |
| | <input type="checkbox"/> Tachycardia (rapid) | | |

Gastro-intestinal

- | | | | | |
|---|--|---|------------------------|-------------|
| <input type="checkbox"/> Nausea | <input type="checkbox"/> Bloating | <input type="checkbox"/> Mucous in stool | Bowel movements: _____ | Color _____ |
| <input type="checkbox"/> Vomiting | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Intestinal pain/cramping | Frequency _____ | Odor _____ |
| <input type="checkbox"/> Acid regurgitation | <input type="checkbox"/> Constipation | <input type="checkbox"/> Itchy or burning anus | Form _____ | |
| <input type="checkbox"/> Gas | <input type="checkbox"/> Use laxative/stool softener | <input type="checkbox"/> Rectal pain or prolapse | | |
| <input type="checkbox"/> Hiccup | <input type="checkbox"/> Black or bloody stool | <input type="checkbox"/> Hemorrhoid | | |
| <input type="checkbox"/> Bad breath | | <input type="checkbox"/> Anal fissures | | |

Musculoskeletal

- | | | | | |
|---|--|---|---|--|
| <input type="checkbox"/> Neck/shoulder pain | <input type="checkbox"/> Low back pain | <input type="checkbox"/> Joint pain (describe)
_____ | <input type="checkbox"/> Limited range of motion
_____ | |
| <input type="checkbox"/> Upper back pain | <input type="checkbox"/> Muscle pain | | <input type="checkbox"/> Other
_____ | |
| <input type="checkbox"/> Mid-back pain | <input type="checkbox"/> Rib pain | | | |

Skin and Hair

- | | | | |
|--------------------------------------|------------------------------------|--|---|
| <input type="checkbox"/> Rashes | <input type="checkbox"/> Psoriasis | <input type="checkbox"/> Hair loss | <input type="checkbox"/> Other
_____ |
| <input type="checkbox"/> Hives | <input type="checkbox"/> Acne | <input type="checkbox"/> Change in hair/skin texture | |
| <input type="checkbox"/> Ulcerations | <input type="checkbox"/> Dandruff | <input type="checkbox"/> Fungal infections | |
| <input type="checkbox"/> Eczema | <input type="checkbox"/> Itching | | |

Neuro-psychological

- | | | | | |
|-----------------------------------|--------------------------------------|---|---|---|
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Poor memory | <input type="checkbox"/> Irritability | <input type="checkbox"/> Considered/attempted suicide | <input type="checkbox"/> Other
_____ |
| <input type="checkbox"/> Numbness | <input type="checkbox"/> Depression | <input type="checkbox"/> Abuse survivor | <input type="checkbox"/> Seeing therapist | |
| <input type="checkbox"/> Tics | <input type="checkbox"/> Anxiety | | | |

Uro-genital

- | | | | |
|---|---|--|---|
| <input type="checkbox"/> Pain on urination | <input type="checkbox"/> Unable to hold urine | <input type="checkbox"/> Decreased libido | <input type="checkbox"/> Nocturnal emission |
| <input type="checkbox"/> Frequent urination | <input type="checkbox"/> Venereal disease | <input type="checkbox"/> Kidney stone | <input type="checkbox"/> Other
_____ |
| <input type="checkbox"/> Urgent urination | <input type="checkbox"/> Bedwetting | <input type="checkbox"/> Impotence | |
| <input type="checkbox"/> Blood in urine | <input type="checkbox"/> Wake to urinate | <input type="checkbox"/> Premature ejaculation | |

Gynecology

- | | | | | |
|--|--|--|---------------------------------------|------------------------------|
| Age menses began _____ | <input type="checkbox"/> Irregular periods | <input type="checkbox"/> Vaginal discharge (color) _____ | <input type="checkbox"/> Breast lumps | Date of last PAP _____ |
| Length of cycle (day 1 to day 1) _____ | <input type="checkbox"/> Painful periods | <input type="checkbox"/> Vaginal sores | #Pregnancies _____ | Date last period began _____ |
| Duration of flow _____ | <input type="checkbox"/> Emotional periods | <input type="checkbox"/> Vaginal odor _____ | #Livebirths _____ | |
| <input type="checkbox"/> Heavy <input type="checkbox"/> Med <input type="checkbox"/> Light | <input type="checkbox"/> Clots | | Age at menopause _____ | |

Anything else?