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HEALTH HISTORY AND CONTACT INFORMATION

Name:	Today's Date:
Address:	Phone (Home):
City: State:	Phone (Work):
Zip:	Phone (Cellular):
Age: Sex:	Ht: Wt:
Email:	
Marital Status:	Occupation:
Place of Birth:	Date of Birth:
Family Physician:	
In Emergency Notify:	Phone Number:
Referred By:	

1.Have you been treated by acupuncture or Oriental medicine before?

2. Main problem(s) you would like us to help you with

3.How long ago did this problem begin (be specific)?

4.To what extent does this problem interfere with your daily activities (work, sleep, sex)?

5.Have you been given a diagnosis for this problem? If so, what?

6.What kinds of treatment have you tried?

7.Past medical history (please include dates):

8.Significant Illnesses: Cancer Diabetes Hepatitis High Blood Pressure Seizures
Heart Disease Rheumatic Fever Thyroid Disease Venereal Diseases Other

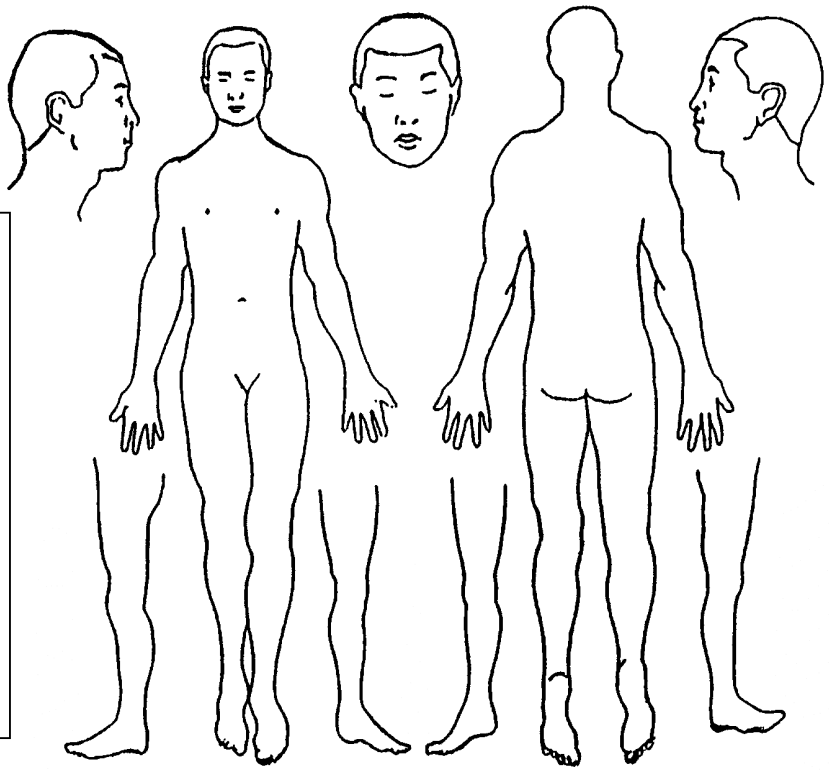
9.Surgeries:

10.Significant Trauma (auto accidents, falls, etc.):

11.Birth History: (prolonged labor, forceps delivery, etc.):

12.Allergies (drugs, chemicals, foods):

13.Indicate painful or distressed areas:



Symbols	
Pain/pressure	X
Swelling	⌒
Tension	+
Weakness	–
Pulsing	✳
Sore	O
Rashes	#
Spasm	→ ←
Temp. Cold	↓
Hot	↑

14.Family Medical History: Diabetes Cancer High Blood Pressure Heart Disease
Strokes Seizures Asthma Allergies Other, please describe:

15.Medicines taken within the last two months (vitamins, drugs, herbs, etc.):

16.Occupation: (Occupational stress (chemical, physical, psychological, etc.):

17. Do you have a regular exercise program? Please describe:

18. Have you ever been on a restricted diet? What kind?

19.Please describe your average daily diet:

Morning Afternoon Evening

20. Do you smoke? How many packs of cigarettes do you smoke a day?

21. How much coffee, tea, or cola do you drink per week?

22.How much alcohol do you drink per week?

23. Please describe any use of drugs for non-medical purposes

Please check if you have had (in the last three months):

24.General

[] Poor Appetite [] Poor Sleeping [] Fatigue
[] Fevers [] Chills [] Night Sweats
[] Sweat Easily [] Tremors [] Cravings
[] Localized Weakness [] Poor Balance [] Change in Appetite
[] Bleed or Bruise Easily [] Weight Loss [] Weight Gain
[] Peculiar Tastes or Smells [] Sudden Energy Drop (What time of day)?
[] Strong Thirst (cold or hot drinks)

25.Skin and Hair

[] Rashes [] Ulcerations [] Hives
[] Itching [] Eczema [] Pimples
[] Dandruff [] Loss of Hair [] Recent moles
[]Any hair or skin problems?

26.Head, Eyes, Ears, Nose, and Throat

[] Dizziness [] Concussions [] Migraines
[] Glasses [] Eye Strain [] Eye Pain
[] Poor Vision [] Night Blindness [] Color Blindness
[] Cataracts [] Blurry Vision [] Earaches
[] Ringing in Ears [] Poor Hearing [] Spots in Front of Eyes
[] Sinus Problems [] Nose Bleeds [] Recurrent Sore Throats
[] Grinding Teeth [] Facial Pain [] Sores on Lips or Tongue
[] Teeth Problems [] Jaw clicks
Headaches (Where and when?)
Any other head or neck problems?

27.Cardiovascular

[] High Blood Pressure [] Low Blood Pressure [] Chest Pain
[] Irregular Heartbeat [] Dizziness [] Fainting
[] Cold Hands or Feet [] Swelling of Hands [] Swelling of Feet
[] Blood Clots [] Phlebitis [] Difficulty in Breathing
Any other heart or blood vessel problems?

28.Respiratory

[] Cough [] Coughing Blood [] Asthma
[] Bronchitis [] Pneumonia [] Pain With a Deep Breath
[] Difficulty in Breathing When Lying Down
[] Production of Phlegm (What color?)
Any other lung problems?

29.Gastrointestinal

[] Nausea [] Vomiting [] Diarrhea
[] Constipation [] Gas [] Belching
[] Black Stools [] Blood in Stools [] Indigestion
[] Bad Breath [] Rectal Pain [] Hemorrhoids
[] Abdominal Pain or Cramps
[] Chronic Laxative Use Any other problems with your stomach or intestines?

30. Genito-Urinary

[] Pain When Urinating [] Frequent Urination [] Blood in Urine
[] Urgency to Urinate [] Unable to Hold Urine [] Kidney Stones
[] Decrease in Flow [] Sores on Genitals
Do you wake up to urinate? How often?
Any particular color of your urine?
Any other problems with your genital or urinary system?

31. Reproductive

A. Female

Number of Pregnancies Number of Births Premature Births
Miscarriages Abortions Age at First Menses
Period Between Menses Duration First Date of Last Menses
[] Unusual Character (Heavy or Light) [] Irregular periods
[] Painful Periods [] Clots [] Last PAP
[] Vaginal Discharge [] Vaginal Sores [] Breast Lumps
[] Changes in Body/Psyche Prior to Menstruation

Do you use birth control? What type and for how long?

B. Male

[] Prostate Issues []Impotence []Other

32.Musculoskeletal

[] Neck Pain [] Muscle Pains [] Knee Pain
[] Back Pain [] Muscle Weakness [] Foot/Ankle Pains
[] Hand/Wrist Pains [] Shoulder Pain [] Hip Pain
Any other joint or bone problems?

33.Neuropsychological

[] Seizures [] Dizziness [] Loss of Balance
[] Areas of Numbness [] Lack of Coordination [] Poor Memory
[] Concussion [] Depression [] Anxiety
[] Bad Temper [] Easily Susceptible to Stress
Have you ever been treated for emotional problems?
Have you ever considered or attempted suicide?
Any other neurological or psychological problems?

34.Comments

Please tell us of any other problems you would like to discuss: