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INTAKE and HEALTH HISTORY

Please complete this document as thoroughly as possible. Some may seem unrelated to your condition, but may be significant in terms of your Chinese medical diagnosis and treatment.

All information is strictly confidential.

I. GENERAL INFORMATION

Date: ___/___/___

Name: _____

Address: _____

City, State, Zip Code: _____

Home Phone: _____ Work Phone: _____

Email address: _____

May myself or my office staff contact you at these phone numbers? Yes No
If No, what is the best way to reach you to retain your privacy? _____

Age: _____ Date of Birth: ___/___/___ Social Security # _____

Gender: M F Height: ___'___" Weight: ___ lbs. Marital Status: _____

Occupation: _____ Employer: _____

Family Physician: _____ Phone: _____

Emergency Contact: _____ Phone: _____

Current Western Diagnoses:

Have you ever been treated by Acupuncture or Oriental Medicine before? Yes No

What are the main issues for which you are seeking treatment?

1. _____

2. _____

3. _____

What are your personal health goals?:

II. MEDICAL HISTORY

How was your health as a child?

List all Hospitalizations, surgeries, auto accidents, and traumas:

Please list any medications, foods or other substances to which you are sensitive or allergic:

List all medications you are currently taking (including over the counter medications and birth control pills):

Name:	Dose:	Frequency:

List any vitamins, herbs, or other supplements you are taking:

Name:	Dose:	Frequency:

III. HEALTH HABITS

Check yes or no for each item. If yes, please specify the frequency:

Cigarette smoking	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____ packs per day/week	type of tobacco_____
Coffee	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____ cups per day/week	<input type="checkbox"/> Reg <input type="checkbox"/> Decaf
Tea	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____ cups per day/week	<input type="checkbox"/> Reg <input type="checkbox"/> Herbal
Alcohol	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____ drinks per day/week	<input type="checkbox"/> Wine <input type="checkbox"/> Beer <input type="checkbox"/> Liquor
Soft drinks	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____ drinks per day/week	<input type="checkbox"/> Regular <input type="checkbox"/> Diet
Artificial Sweeteners	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____ packs per day/week	

Amount of fluid consumption per day _____ plain water _____ juice _____ other _____

What exercises/activities do you do and how frequently? _____

How many hours of sleep do you get per night? _____ Is it restful? _____

Do you have an adequate energy level? _____

Mark the stress level in your life (0 is the least, 10 is the most): _____

How much does stress affect you (0 is the least, 10 is the most)? _____

What is your job satisfaction (0 is the least, 10 is the most)? _____

What are the major stressors in your life? _____

IV. DIET

Briefly describe your diet:

How do you feel after eating (energized, tired...)? _____

How often to you eat out? _____

What type food do you like? _____

Do you prefer your food to be hot or cold in temperature? _____

Favorite foods? _____ Foods you dislike? _____

Do you crave sweets? _____ When? _____

Are you on any specific type of diet? _____

Do you feel good about your body and your current weight? _____

Would you like to decrease or increase your weight? _____

When did you last have a significant weight change? _____

V. GENERAL HEALTH SURVEY

Please indicate any conditions you have now or have had in the past. Write “C” for current and “P” for past conditions:

GENERAL

- Fever, chills, sweats
- Night sweats
- Fatigue
- Nervousness/anxiety
- Irritability
- Depression
- Generally feel “run down”
- Sexual abuse (optional)
- Emotional abuse (optional)
- Loss of weight

SKIN

- Non-healing sore
- Hives, rash
- Eczema, psoriasis
- Frequent infection or boils
- Abnormal pigmentations, moles
- Warts
- Herpes:
 - lips
 - genital
 - zoster (shingles)
- Skin cancer or melanoma
- Brittle or weak nails
- Infected nails

ENDOCRINE

- Diabetes
- Thyroid disease
- Heat or cold intolerance
- Dry skin
- Change in hair growth or texture
- Excessive thirst or urination
- Sexual problems
- Hormone therapy
- Low or high sex drive
- Radiation to neck or face area
- Low blood sugar

HEAD-EYES-EARS-NOSE-THROAT

- Headache
- sinus (allergy)
- tension
- migraine
- Head feels “heavy”
- Loss of memory
- Light-headedness
- Light bothers eyes
- Eye disease or injury
- Blurry vision
- Double vision
- Loss of vision
- Glaucoma, cataracts
- Loss of balance
- Dizziness or vertigo
- Loss of hearing
- Ear disease
- Impaired hearing
- Ringing/buzzing in ears
- Ear pain
- Discharge from ear
- Runny nose or nasal discharge
- Nosebleeds
- Chronic sinus trouble

- Snoring
- Sore throats
- Hoarseness
- Tooth & gum problems
- Loss of taste
- Sores in mouth
- Sore tongue

RESPIRATORY

- Frequent “colds”
- Difficulty breathing
- Chronic or frequent cough
- Asthma or wheezing
- Emphysema
- Spitting up blood
- Pleurisy (pain with breathing)
- Pneumonia
- Coughing up sputum

CARDIOVASCULAR

- High blood pressure
- Palpitation, irregular heart beat
- Rheumatic fever
- Chest pain or angina
- Shortness of breath with walking
- Shortness of breath lying down
- Difficulty walking two blocks
- Heart trouble
- Heart attack
- Heart murmur
- Awakening in the night smothering
- Swelling of hands, feet, or ankles
- Restless legs
- Pain in calves
- Varicose veins

HEMATOLOGIC

- Excessive bleeding/bruising
- Anemia
- Phlebitis/blood clots in veins
- Are you slow to heal after cuts or bruising?
- Difficulty with bleeding excessively
- Mononucleosis

GASTROINTESTINAL

- Painful bowel movement
- Vomiting blood or food
- Heartburn/indigestion
- Food sticks in throat
- Difficulty swallowing
- Diarrhea or loose stools
- Ulcer (stomach or duodenal)
- Gallbladder disease or stones
- Liver trouble/hepatitis
- Bloody or black stools
- Constipation
- “Nervous” stomach
- Nausea and/or vomiting
- Bloating in stomach after eating
- Bloating or gas in lower abdomen
- Soft, unformed stools:
- Constipation

GENITOURINARY

- Frequent urination
- Involuntary loss of urine

- Burning or painful urination
- Blood in urine
- Straining to urinate
- Hernia
- Sexually transmitted disease
- Kidney stones
- Kidney infections

FEMALE

- Last menstrual period ____ date
- Currently pregnant
- Age periods started
- Duration of flow ____ days
- Days in cycle ____ days
- Pelvic pain or infection
- Excess discharge
- Excess discharge
- PMS
- Menstrual cramping
- Irregular cycle
- Number of pregnancies
- Number of children
- Number of ectopic pregnancies
- Number of miscarriages
- Number of abortions
- DES exposure
- Uterine fibroids
- Hysterectomy
- Date of menopause ____
- Hot flashes
- Menopausal bleeding
- Breast pain
- Breast lumps
- Nipple discharge or bleeding
- Abnormal PAP smear

MALE

- Testicular pain/swelling
- Urinary frequency or burning
- Difficulty in starting stream of urine
- Discharge from penis
- Frequent night urination
- Prostate pain/swelling
- Undescended testicle
- Impotence

LOCOMOTOR-MUSCULOSKELETAL

- Joint swelling
- Arthritis or joint pain
- Weakness of muscles or joints
- Back pain (see next page)
- Difficulty walking
- Leg cramps
- Leg ulcers

MENTAL EMOTIONAL/NEUROLOGIC

- Fainting spells
- Epilepsy/Seizures
- Stroke or mini-stroke
- Paralysis
- Weakness of an arm or leg
- Insomnia or trouble sleeping
- Anger/irritability
- Sadness/grief/depression
- Anxiety/fear
- Mental overactivity

VI. PAIN CONDITIONS

Indicate any areas of pain in the body:

Is the pain sensation:

Sharp Burning Aching Cramping Dull Moving Fixed

Do any of the following lessen the pain:

Pressure Cold Heat Exercise Other:

Do any of the following worsen the pain:

Pressure Cold Heat Exercise Other:

VII. FAMILY HEALTH HISTORY

Please specify the health of your family members as Excellent, Good, Fair, or Poor. Indicate if they have any of the following: allergies or asthma, anemia, arthritis, bleeding tendencies, cancer, colitis, depression, diabetes, drug or alcohol abuse, epilepsy, heart disease, high blood pressure, immunologic disease, kidney or bladder trouble, liver disease, mental illness, migraines, obesity, osteoporosis, stomach issues, stroke, TB, other. If Deceased, please list the cause and at what age they passed.

Father: _____

Mother: _____

Siblings: _____

Children _____

Grandparents: _____

Patient Signature: _____

Acupuncturist Signature: _____