Wholistic Acupuncture & Yoga Wellness Center

Patient Health History Questionnaire

NAME_____ TODAY'S DATE_____

ADDRESS_____CITY_____ZIP_____

PHONE: Preferred_____Other_____

Age_____ Date of Birth_____

E-Mail_____Would you like to receive our e-newsletter? Yes___ No___

Occupation_____Employer_____

PHYSICIAN/Clinic_____

EMERGENCY CONTACT_____Phone_____

How did you hear about us?_____

Have you previously received acupuncture? _____ Have you previously received massage? _____
Do you have a pacemaker? ___Yes ___No Do you wear: contact lenses?_____hearing aid?_____

Main condition/s you would like to resolve_____

_____

_____

Time of Onset and Cause/s (if known) of your condition/s_____

_____

Please list any diagnoses you have been given_____

What treatments have you tried, & did they help/worsen your condition?_____

_____

Your Past Medical History (please include month/year when the diagnosis was established)
Cancer_____ Hepatitis_____ Thyroid Disease_____Seizures_____Fibromylagia_____ Tuberculosis_____
Hypertension_____Blood Clots_____ Anemia_____ Arthritis_____ Breathing Problems_____ Diabetes_____
Heart Disease_____ Digestive Disorders_____HIV/ Aids Positive_____Venereal Disease _____Broken Bones_____
Contagious Skin Disorder _____Open wounds____Bruise easily____Artificial Joint_____ MS_____ Parkinson's_____
Other (please specify) _____

Surgeries / Hospitalization/Traumas (type and date) _____

_____

Allergies (including reactions to skin care products)
_____

Medicines (prescribed & non-prescribed), Herbs, Vitamins, etc. taken consistently the last two months_____

Family Medical History (please specify family member)
Cancer Diabetes Hepatitis Hypertension
Heart Disease Stroke Asthma Alcoholism Miscarriage
Psychiatric or Emotional Imbalance Other_____

Lifestyle Information:
Height_____Weight now _____ Weight one year ago_____Weight maximum_____

Occupational Stress? (chemical, physical, psychological) _____

Describe your average week's exercise_____

Are you on a restricted diet? No____ Yes____ Describe _____

Cigarette Smoking (brand, quantity, & years)_____

Do any other non-medical drugs?_____

How much coffee, tea, cola & diet soda do you drink per week? _____

How much water do you drink per day?_____

How much alcohol do you drink per week? _____

How many hours per day do you sleep?_____Do you sleep well?_____

On average, describe your energy level on a scale of 1-10(highest) _____

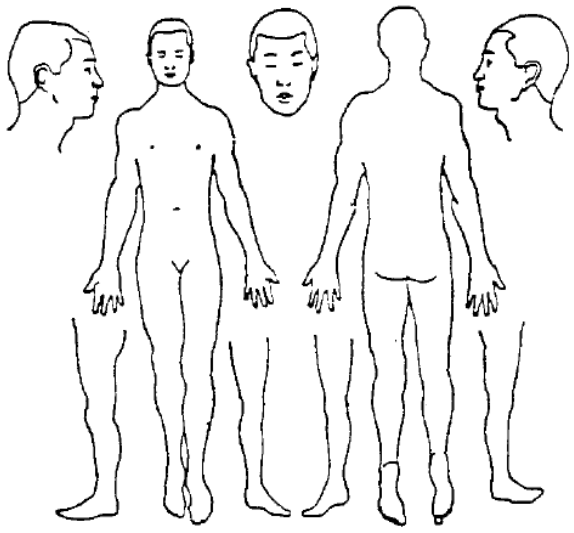
List the three most significant events in your life. Are any of these situations continuing to impact your life?

_____

_____

_____

Indicate Painful or distressed areas:



Do you have any difficulty lying on your front, back, or side? Yes No
If yes, please explain

Please check if you have or have had in the <u>past three months</u> any of the following diseases or conditions.

- o Poor sleep/Insomnia
- o Fatigue
- o Fever
- o Chills
- o Night Sweats
- o Sweat easily
- o Bleed or bruise easily
- o Strong thirst
- o Sudden energy drop

Skin/Hair

- o Rashes
- o Ulcerations
- o Hives
- o Itching
- o Shingles
- o Eczema
- o Pimples/Acne
- o Dandruff
- o Dry Skin
- o Recent moles or warts
- o Loss of Hair
- o Changes in hair or skin
- o Fungal Infections

Musculoskeletal

- o Rheumatoid Arthritis
- o Osteoarthritis
- o Tendonitis
- o Osteoporosis
- o Weakness in muscles
- o Pain in muscles
- o Difficulty Walking
- o Cold hand/feet
- o Swelling of hand/feet
- o Spinal curvature
- o Hernia
- o Numbness/Tingling
- o Tremors
- o Paralysis
- o Sprain of joint

Head, eyes, ears, nose and throat

- o Dizziness
- o Concussions
- o Migraines or headaches
- o Eye strain or pain
- o Night Blindness
- o Poor Vision
- o Cataracts
- o Blurry Vision
- o Spots in vision
- o Earaches
- o Ringing in ears
- o Poor hearing
- o Sinus problems
- o Nose bleeds
- o Sore throat
- o Grinding teeth
- o Teeth problems
- o Facial pain
- o Jaw clicks/ TMJ
- o Sores on lips, tongues
- o Difficulty swallowing

Cardiovascular

- o High blood pressure
- o Low blood pressure
- o Chest pain
- o Palpitations
- o Fainting
- o Phlebitis
- o Irregular Heartbeat
- o Varicose veins
- o Other:

Respiratory

- o Cough
- o Coughing blood
- o Wheezing
- o Difficulty breathing
- o Bronchitis
- o Pneumonia
- o Chest pain
- o Esophageal pain
- o Production of phlegm- what color?_____

Gastrointestinal

- o Nausea/Vomiting
- o Diarrhea
- o Constipation
- o Chronic laxative use
- o Gas
- o Belching
- o Black stools
- o Blood in stools
- o Indigestion/GERD
- o Bad breath
- o Rectal pain
- o Hemorrhoids
- o Abdominal pain
- o Gallbladder problems
- o Parasites
- o Poor appetite
- o Cravings
- o Crohn's
- o Irritable Bowel/Colitis
- o Peculiar taste

Neurological- Psychological

- o Loss of balance
- o Lack of coordination
- o Depression
- o Anxiety
- o Stress
- o Bad temper
- o Bi-polar
- o Eating Disorder
- o Other psychiatric diagnosis

Genito-urinary

- Pain on urination
- Frequent urination
- Blood in urine
- Urgent to urinate
- Kidney stones
- Unable to hold urine
- Chronic bladder infection
- Kidney infection
- Pause of urine flow
- Pain in genitals
- Itching of genitals
- Sores on genitals
- Other:

Female

- Frequent vaginal infections
- Pelvic infection
- Endometriosis
- Vaginal itching/discharge
- Fibroids
- Ovarian cysts
- Irregular periods
- Clots
- Pain/cramps prior/during periods
- Breast tenderness
- Breast lumps
- Fertility problems
- Hot flashes
- Moodiness related to periods

_____number of pregnancies
_____number of births
_____miscarriages
_____abortions
_____premature births
_____cesareans
_____difficult delivery

First date of last period_____ Duration of periods _____days, cycle _____days

Do you practice birth control? Yes no If yes, what type and for how long?_____

Any chance you are pregnant? ___Yes ___No

Male

- Prostate problems
- Discharge
- Impotence
- Frequent seminal emission
- Fertility problems
- Ejaculation problems
- Painful/swollen testicles
- Other_____

I understand the above information and guarantee this form was completed to the best of my knowledge.

_____Date_____

Signature

- Adult patient
- Parent or Guardian
- Spouse

Any other information you would like to give me?