



Acupuncture & Herbal Clinic

Patient Health History

Name: _____ Date: _____
(First) (Middle) (Last)

Street Address: _____ City: _____ State: _____ ZIP Code: _____

Contact Tel. No.: _____ E-mail: _____ Date of Birth: _____ Gender: _____

Marital Status: _____ Emergency Contact: _____ Telephone: _____ Relationship: _____

Ethnicity: (optional – for statistical purposes only)
___ Asian ___ Native American ___ African American ___ Hispanic ___ Pacific Islander ___ Caucasian ___ Other

How did you hear about us? (please circle at least one):
___ OCOM Student ___ Friend ___ Television ___ Radio ___ Newspaper ___ Other, please explain: _____

Successful health care and preventative medicine are only possible when the physician has a complete understanding of the patient physically, mentally, and emotionally. Please complete this questionnaire as thoroughly as possible.

1. Are you currently receiving health care? Y N If yes, where and from whom? _____

_____ If no, when and where did you last receive health care? _____ For what reason? _____

2. Has your case been referred to an attorney (Work Comp, personal injury or motor vehicle injury claim, etc.)? Y N

3. Please identify the health concerns that have brought you to the clinic below:

<u>Condition</u>	<u>Past Treatment</u>
a. _____	_____
b. _____	_____
c. _____	_____

4. Are you pregnant or is there any possibility you could be pregnant? Y N

5. Do you have any chronic infectious diseases? Y N If yes, please explain: _____

6. Are you currently suffering from any chronic illness? Y N If yes, please explain: _____

7. Significant diseases, injuries, accidents, hospitalizations, surgeries, X-Rays/CAT Scans/MRI's/NMR's/Special Studies:
Reason When Reason When

_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

8. Please list any prescriptive medications, over-the-counter medications, vitamins, and supplements that you are currently taking and give your dosage: (Or provide a list of medications to your provider.)

9. Please list any foods, drugs, or medications you are hypersensitive or allergic to (please include the type of reaction):

10. **Height:** _____ **Weight:** Currently: _____ Past Maximum Weight: _____ When? _____

11. **Blood Pressure:** What is your most recent blood pressure reading? ____/____ When was this reading taken? _____

12. **Immunizations** (please circle any that you have had):

Polio Tetanus Measles/Mumps/ Rubella Pertussis Diphtheria Hepatitis B Others: _____

13. **Family History:**

	Mother	Father	Brothers	Sisters
Age if living:				
Health (G=good, P=poor)				
Age at death (if deceased)				
Cause of death				
Check off family illnesses:	Mother	Father	Brothers	Sisters
Cancer				
Diabetes				
Heart Disease				
High Blood Pressure				
Stroke				
Mental Illness				

14. **Emotional** - please circle any that you experience currently.

Mood Swings Depression Anxiety Mental Tension Past Traumas _____

15. **Energy and Immunity** - please circle any that you experience currently.

Fatigue Slow Wound Healing Chronic Infections Chronic Fatigue Syndrome Other _____

16. **Head, Eye, Ear, Nose & Throat** – please circle only ones that you experience currently.

Ear Ringing Headaches Sinus Problems Frequent Sore Throat TMJ/Jaw Problems Hay Fever/Allergies

17. **Respiratory** - please circle any that you experience currently.

Pneumonia Frequent Common Colds Difficulty Breathing Persistent Cough Asthma Other: _____

18. **Cardiovascular** - please circle any that you experience currently.

Heart Disease Chest Pain High Blood Pressure Palpitations/Fluttering Other: _____

19. **Gastrointestinal** - please circle any that you experience currently.

Nausea/Vomiting Epigastric or Abdominal Pain Heartburn Gall Bladder Disease Liver Disease

Hemorrhoids Chronic Diarrhea Chronic Constipation Blood in Stool Other: _____

20. **Genito-Urinary Tract** - please circle any that you experience currently.

Kidney Disease Painful Urination Blood in Urine Nighttime urination Incontinence Other: _____

21. **Female Reproductive** - please circle any that you experience currently.

Irregular Cycles Bleeding Between Cycles Vaginal Discharge Premenstrual Problems Menopausal Symptoms

Pelvic pain Infertility Other: _____

22. **Menstrual/Birthing History:**

No. of Pregnancies:		No. of Live Births:		No. of Miscarriages:	
No. of Days of Menses:		Days in Cycle:		Type of Birth Control, if any:	

23. **Male Reproductive** - please circle any that you experience currently.

Sexual Difficulties Prostate Problems Other: _____

24. **Musculoskeletal** - please circle any that you experience currently.

Neck/Shoulder Pain Muscle Spasms/Cramps Arm Pain Leg Pain

Back Pain, if so, where?: _____ Joint Pain (if so, where?): _____

25. **Neurological Problems** - please circle any that you experience currently.

Vertigo/Dizziness Paralysis Numbness Loss of Balance Seizures Stroke Other _____

26. **Endocrine and metabolic disorders** - please circle any that you experience currently.

Hypothyroidism Hypoglycemia Hyperthyroidism Diabetes Mellitus Night Sweats Other _____

27. **Other** - please circle any that you experience currently.

Anemia Cancer Rashes Eczema/Hives Cold Hands/Feet Other _____

28. **Lifestyle:**

a. Please indicate typical food and beverage intake:

Breakfast	Lunch	Dinner	Snacks

b. Daily Exercise: _____ Sleep: Good or Poor No. of Hours _____ Dreams: Y N

c. Occupation: _____ Employer: _____ Hours/Week: _____ Enjoy your work? Y N

d. Nicotine and Tobacco Use Per Day: _____

e. Alcohol Consumption Per Week: _____ Caffeine Consumption Per Week: _____