Desert Health Community Acupuncture

HEALTH HISTORY

Date: ____ / ____ / ______

Name:			Sex:	Age:
Address:		City:	State:	Zip Code:
Phone #1: Home Cell Other	Phone #2: Work Cell Other	Email:		
Date of Birth:	Emergency Contact: *(name & relationship)*	Phone #:		
Height:	Weight:	Relationship Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Living w/partner ☐ Other :__________		
Occupation:		Employer:		
How did you hear of our clinic?: ☐ Word of Mouth ☐ Internet ☐ Yellow Pages ☐ Craigslist ☐ Flyer ☐ Walk / Drive by ☐ Print Ad ☐ Other :___________		Referred by:		
Physician:	Phone #:	Have you been treated by Acupuncture or Oriental Medicine Before? ☐ No ☐ Yes ____/____/____		

MAIN COMPLAINTS

Please write in your top 3 health complaints / concerns in order of importance to you. Circle the items that make it better or worse and mark on the scale from 1-10 the severity of the condition (1=no symptoms, 10=worst ever)

1 ______________________________

When did this start? ________________ago

Heat makes it:	better	no change	worse
Cold makes it:	better	no change	worse
Damp weather:	better	no change	worse
Exercise / Activity:	better	no change	worse

1 |—————|—————| 10

2 ______________________________

When did this start? ________________ago

Heat makes it:	better	no change	worse
Cold makes it:	better	no change	worse
Damp weather:	better	no change	worse
Exercise / Activity:	better	no change	worse

1 |—————|—————| 10

3 ______________________________

When did this start? ________________ago

Heat makes it:	better	no change	worse
Cold makes it:	better	no change	worse
Damp weather:	better	no change	worse
Exercise / Activity:	better	no change	worse

1 |—————|—————| 10

HEALTH HISTORY

Circle the (person icon) if you have / had the condition and note the year it started.
Circle the (family icon) if there is a family history of the condition.

Condition	YOU	Year	FAMILY
Cancer *type(s)?* ____________	☨	_______	☨☨☨
Diabetes	☨	_______	☨☨☨
Hepatitis	☨	_______	☨☨☨
High Blood Pressure	☨	_______	☨☨☨
Heart Disease	☨	_______	☨☨☨
Stroke	☨	_______	☨☨☨
Seizure Disorder	☨	_______	☨☨☨
Thyroid Disease	☨	_______	☨☨☨
Asthma	☨	_______	☨☨☨
Pacemaker	☨	_______	☨☨☨
Osteoporosis	☨	_______	☨☨☨
Herpes	☨	_______	☨☨☨
AIDS / HIV	☨	_______	☨☨☨
Other STD	☨	_______	☨☨☨
Rheumatic Fever	☨	_______	☨☨☨
Alcoholism	☨	_______	☨☨☨
Allergies *type(s)?* ____________	☨	_______	☨☨☨
Mental Illness	☨	_______	☨☨☨
Kidney Disease	☨	_______	☨☨☨
Anemia	☨	_______	☨☨☨

HABITS

	Amount / Week	If Quit, Year?
Coffee / Tea	______________	_______
Soda	______________	_______
Tobacco	______________	_______
Alcohol	______________	_______
Drugs	______________	_______

EXERCISE

Do you exercise regularly? ☐ Yes ☐ No

If so, what and how often:

____

____

____

DIET

Do you have a special diet now or in the past? (vegetarian, vegan, raw, Atkins, etc.)

Describe w/ dates:

MEDICATONS

Please note what medications, herbs or supplements that you take regularly

____

____

____

INJURIES & SURGERIES

Please note what happened to what body area and when it occurred (incl. dental)

____

____

____

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HEALTH HISTORY FOR MEN

Please mark an X on the scales and check any boxes of symptoms you have had in the past month

TEMPERATURE

How warm / cold you feel (not in degrees); relative to other people do you wear more or less layers, etc.

COLD |——————|——————| HOT

- ☐ Cold hands or feet
- ☐ Chills
- ☐ Cold "in the bones"
- ☐ Areas of numbness
- ☐ Thirst for cold/hot drinks
- ☐ Thirst, no desire to drink
- ☐ Absence of thirst
- ☐ Excessive thirst
- ☐ Night sweats
- ☐ Unusual sweats
  When_______am / pm
  Where on body_________
- ☐ Hot hands, feet, chest
- ☐ Hot flashes
- ☐ Hot in afternoon
- ☐ Hot at night

MOISTURE

Your overall body moisture (hair, skin, mouth, bowels, etc.)

DRY |——————|——————| OILY

- ☐ Dry skin
- ☐ Dry hair
- ☐ Dry eyes
- ☐ Dry brittle nails
- ☐ Dry mouth
- ☐ Dry lips
- ☐ Dry throat
- ☐ Dry nose / Nosebleeds

Where on your body?:

- ☐ Edema / Swelling ______________
- ☐ Rashes ______________________
- ☐ Itching _______________________
- ☐ Dandruff
- ☐ Oily skin
- ☐ Oily hair
- ☐ Pimples
- ☐ Weight gain / loss

DIGESTION

DIARRHEA |——————|——————| CONSTIPATION

BM: How often? _____x / every _____days
Stools keep shape? ☐ Y ☐ N

- ☐ Alternating diarrhea & constipation (IBS)
- ☐ Indigestion
- ☐ Gas
- ☐ Bloating
- ☐ Belching
- ☐ Poor appetite
- ☐ Nausea / Vomiting
- ☐ Bad breath
- ☐ Heartburn
- ☐ Excessive hunger
- ☐ Dry Stools
- ☐ Difficult to pass
- ☐ Tired after BM
- ☐ Foul smelling stools

ENERGY

LOW |——————|——————| HIGH

- ☐ Sudden energy drop
  Time of day: _____ am / pm
- ☐ Energy drop after eating
- ☐ Fatigue
- ☐ Dependence on caffeine / stimulants
- ☐ Wired / ungrounded feeling
- ☐ Body / Limbs feel heavy
- ☐ Body / Limbs feel weak
- ☐ Shortness of breath
- ☐ Heart Palpitations
- ☐ Blood pressure High / Low
- ☐ Bleed / Bruise easy
- ☐ Hard to concentrate
- ☐ Poor memory
- ☐ Dizziness / lightheaded
- ☐ Headaches _____x / week

SLEEP

\# hours per night ______

- ☐ Difficulty falling asleep
- ☐ Wake ___x/ night @_____am / pm
- ☐ Wake to urinate *How often?_______*
- ☐ Disturbing dreams
- ☐ Restless sleep
- ☐ Not rested upon waking

EMOTIONS

What emotion(s) dominate your experience?

- ☐ Anger
- ☐ Irritability
- ☐ Anxiety
- ☐ Worry
- ☐ Obsessive thinking
- ☐ Sadness
- ☐ Grief
- ☐ Depression
- ☐ Joy
- ☐ Fear
- ☐ Timid / shy
- ☐ Indecision

EYES, EARS NOSE THROAT

- ☐ Poor vision
- ☐ Night blindness
- ☐ Red eyes
- ☐ Itchy eyes
- ☐ Spots in front of eyes
- ☐ Sinus congestion
- ☐ Phlegm (*color*________)
- ☐ Poor hearing
- ☐ Ringing in ears
- ☐ Excess earwax
- ☐ Sore throat
- ☐ Dental problems
- ☐ Mouth sores
- ☐ Cough

URINARY

Fluid in = fluid out? ☐ Y ☐ N

- ☐ Decrease in flow
- ☐ Dribbling
- ☐ Difficulty starting / stopping
- ☐ Incontinence
- ☐ Kidney stones
- ☐ Urgency to urinate
- ☐ Frequent urination
- ☐ Pain on urination
- ☐ Burning sensation
- ☐ Cloudy urine
- ☐ Blood in urine

REPRODUCTIVE

Are you sexually active? ☐ Y ☐ N

- ☐ Change of sexual drive: ⇧ ⇩
- ☐ Erectile dysfunction
- ☐ Premature ejaculation
- ☐ Sores on genitals
- ☐ Discharge
- ☐ Prostate disease
- ☐ Genital Pain
- ☐ Jock Itch
- ☐ Vasectomy
- ☐ Hernia
- ☐ Hemorrhoids