



Health History

Name: _____ Date: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____

Cell: _____ E-mail Address: _____

Occupation: _____

Age: _____ Date of birth: _____ Female....._1 Male....._2

Emergency Contact (Name & relation): _____ Phone _____

Marital Status (Please check most current status)

- _1Married or living with significant other
- _2Divorced/Separated
- _3Widowed
- _4Never been married

How were you referred for this appointment? (check all that apply)

- _1Word of mouth (patients, family, friends, co-workers)
- _2Mailing (letter, postcard, flyer)
- _3Another healthcare practitioner (MD, RN, DC, L.Ac., Massage therapist)
- _4Event (lecture, retreat, health fair)
- _5Website
- _6No Referral
- _7Other: _____

Have you ever been treated with Traditional Chinese Medicine?

- _0No
- _1Yes

What health concern would you like addressed today?

What do you feel is the cause of this health concern?

What makes your condition better?

What makes it worse?

What is the severity of your health concern TODAY?

(Circle only one number)

None 0	1	2	3	4	5	6	7	8	9	Most 10
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On average, what was the typical severity of your health concern in the LAST WEEK?

(Circle only one number)

None 0	1	2	3	4	5	6	7	8	9	Most 10
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Have you seen another health care provider for this?

₀No

₁Yes

When: _____

Provider: _____

Have you been diagnosed by a medical doctor?

₀No

₁Yes

Diagnosis: _____

If you have been seen by another provider, are you continuing under their care?

₀No

₁Yes

If no, why not? _____

For what else do you regularly see a doctor? (Include all diagnoses you've been given)

Diagnosis	Date of diagnosis

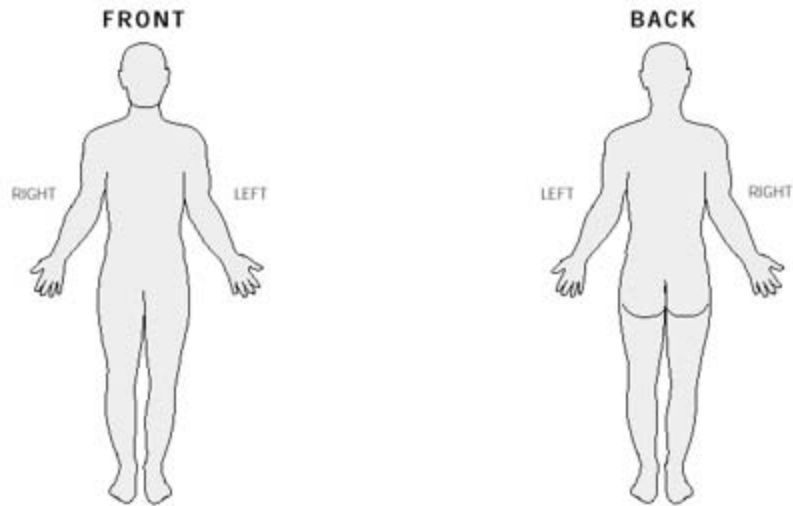
	Describe	Date
Past Traumas		
Accidents		
Surgeries		
Allergies (food, medicine, etc.)		
Parents Medical History		
Grandparents Medical History		

The following sections refer to experiences and lifestyle patterns that are important in diagnosing a traditional Chinese medicine pattern. Please indicate how often you experience each item by marking one box per statement.

	Never	At times	Often		Never	At times	Often
Limbs/Back				I have a stiff neck.			
I have muscle weakness.				My body joints feel stiff / hurt			
I have muscle pain.				My back hurts.			
I feel numbness / tingling				I have knee pain.			
I get muscle spasms				I have leg pain.			
I have tremors.				Other:			
It is difficult for me to walk.							

Use this diagram to show where you have your pain. Mark the area with the symbol that best describes your pain:

- | | | | |
|--------------|----------|------------------|----------|
| Aching Pain | ***** | Pins and needles | OOOOO |
| Burning Pain | xxxxxxxx | Stabbing pain | //////// |
| Numbness | ===== | | |



	Never	At times	Often		Never	At times	Often
Activity				Habits			
I exercise or do sports.				I drink caffeinated drinks.			
I do tai chi, yoga or qi gong.				I drink alcohol.			
Nutrition				I smoke.			
I eat meals at regular times.				I do recreational drugs.			
I overeat / under eat				Spirituality			
I follow a special diet (e.g., vegetarian, low-carb, low-salt)				I engage in a spiritual community.			
I overeat.				I pray / meditate.			
I undereat.				Relationships			
I eat sugar / fast food.				I share myself with someone special.			
I lose my appetite.				I feel supported by others.			
I crave certain foods. (sweet, salty, greasy, etc)				I get together with friends.			
				My home life is comfortable.			
				My work is satisfying.			

	Never	At times	Often		Never	At times	Often
Energy / Sleep				I have cold hands and feet.			
I feel tired or fatigued.				I feel thirsty.			
I have trouble falling asleep.				Thoughts / Emotions			
I wake up at night.				I make decisions easily.			
I wake up too early.				It is difficult to think clearly.			
I remember my dreams.				I remember things easily.			
Temperature				I worry.			
I feel warm.				I feel afraid.			
I feel cool.				I feel depressed or sad.			
I feel hot at night.				I feel irritable.			
I sweat easily, even when I am not exercising.				I feel happy or joyful.			
I sweat at night.				I feel anxious.			

	Never	At times	Often		Never	At times	Often
Head/Eyes/Ears				I feel dizzy.			
My vision is blurry.				My ears ring.			
I see floaters.				Chest/Lungs/Heart			
My eyes are red / dry / itchy.				I wheeze.			
I have sinus problems.				I cough.			
I have headaches.				I have chest pain.			
I have a sore throat.				It is hard for me to breathe.			
I have a dry mouth.				My heart races.			
My jaw hurts.				My heart skips a beat.			
I have dental problems.				I feel my heart beating.			
I have mouth sores.				I feel a "stitch" in my side.			

	Never	At times	Often		Never	At times	Often
Digestion				Urine			
I feel bloated.				I have urinary frequency.			
I belch.				I get up at night to urinate.			
I get heartburn / acid reflux.				My urine is cloudy.			
I pass gas.				My urine burns.			
I get abdominal cramps.				I can't control my urine.			
I have hemorrhoids.				I get urinary tract infections.			
My stools are hard to pass.				My urine smells funny.			
I have loose stools.				Skin/Hair			
I feel nauseous				I have skin rashes / lesions.			
I vomit.				I have acne.			
I am tired after eating.				I bruise easily.			
				I am losing my hair.			

	Never	At times	Often		Never	At times	Often
Reproduction				Reproduction			
Women				Men			
My menstrual cycle is regular.				My genitals itch.			
I have menstrual cramps.				I have a genital rash.			
I have PMS.				I have genital pain.			
My breasts are tender before my period.				I experience sexual dysfunction.			
I have ovarian cysts/fibroids.				I have prostate problems.			
I have vaginal discharge.							
I get yeast infections.							

For women only:

How old were you when your period started?_____

Describe your menstrual flow (circle one).....light medium heavy

How many days is your flow?_____

Do you get menstrual blood clots? (circle).....none some many

Date of the first day of your last period._____

How many times have you been pregnant?_____

How many live births have you had?_____

How many miscarriages or abortions?_____

Age of menopause....._____

Is there anything else you want me to know?

