Lesha Jacyszyn L.Ac. Acupuncture For Digestive Health LLC

Patient Medical History Record

Name		Home Phone	Cell Phone
Street Address		Email Address	
City		Emergency Contact Name: _____	
State	Zip	Phone number: _____	
date of birth	Occupation	Relationship: _____	

Primary Care physician name and phone number:	Referred by:

Age	Height	Weight	Gender
Main problem and when it began			
Other concurrent therapies			

Family History of Illness

Place a check mark in the box if you or a family member have had the following illnesses.
If you have had the illness yourself please indicate the date(s) when your illness occurred.

Disease	Yourself	Father	Mother	Sibling	Grandparent
Cancer					
Diabetes					
High blood pressure					
Heart Disease					
Hepatitis B and/or C					
Asthma					
Thyroid disease					
Seizures					
Rheumatic fever					
HIV or AIDS					

Personal Medical History	
Surgeries that you have had and when?	
Significant accidents/trauma (car, falls) when?	
Occupational Stresses (chemical, physical, psychological, etc.	
Exercise (what type, how many times per week, for how long?	

Dietary and Nutritional Assessment

Reason for nutrition counseling and goals: (if applicable)

Current diagnosis if applicable:

Current medications, Chinese herbs, vitamins and/or supplements: **IMPORTANT** do not leave blank
(This is to avoid herb/drug interractions)

Pertinent laboratory values: (if known)

Medical history: (other than stated above)

Family medical history:(Other than stated above)

Physical Status:
Height: _____ Weight: _____

Usual adult body weight: _____ (Highest _____ at age_____) (lowest _____ at age_____)

Any recent weight loss or gain? YES / NO

If yes, how much and in how much time? _____

Diet:

On a special or restricted diet? YES / NO

If yes, what is it called? (Ex. Vegetarian, vegan, paleo, atkins, etc.) Or what are the restrictions?

Do you have any food allergies? (produces hives and/or anaphylactic shock)

Do you have any known food sensitivities or intolerances? (gluten, lactose, casein, etc.)

How many meals do you eat a day? _____

How many snacks? _____

How often do you eat at restaurants, consume take out or fast food per week? _____

How many ounces of water do you drink per day? _____

How many ounces of caffeinated coffee do you drink per day?_____

How many ounces of soda or juice do you drink per day? _____

How many ounces of caffeinated tea do you drink per day? _____

How many ounces of Gatorade or energy drinks do you drink per day? _____

How many alcoholic beverages do you drink per day? (one drink equals one glass of wine, one beer, one shot of liquor either straight or mixed) If only on some days, on average how many per week?

Describe your typical eating environment (ex. alone, with friends or family, at your desk, at a computer while working, in the car on the go, standing, sitting at a table, while watching television, etc)

Are you comfortable with your body size and appearance? Yes / No / Sometimes

Fasting blood glucose levels: _____

Cholesterol levels: HDL_____ LDL_____ VLDL_____

Blood pressure: _____