Confidential Health History

Welcome! We want to make your appointment as pleasant and comfortable for you as possible.
If at any time you have questions regarding your visit, please let us know.

Name_____ E-Mail_____ Phone (H)_____ (W)_____

Address_____ City_____ State_____ Zip_____

Today's Date_____ Date of Birth_____ Age_____ M_____ F_____ Marital Status _____ # of Children_____

Occupation_____ Height_____ Weight_____ Referred by _____

Primary health complaint_____

Secondary health complaint_____

How long have you had this condition?_____ What brought it on?_____

Does it affect your: ☐ work ☐ sleep ☐ eating ☐ other (*explain*)_____

What activities or times aggravate condition? _____

What activities or times improve condition?_____

What do you believe is wrong with you?_____

What have you done to get relief?_____

Have you been given a diagnosis for the problem by your family physician? (*explain*)_____

Physician_____ Have you had acupressure before?_____ Chinese herbal medicine_____

Drugs_____

Vitamins/supplements_____

Herbs_____

AVERAGE DAILY DIET:

Morning	Afternoon	Evening

HABITS
☐ Alcohol ☐ Artificial sweetener ☐ Caffeinated coffee/tea ☐ Chocolate ☐ Cola
☐ Drugs ☐ Exercise ☐ Salt ☐ Sugar ☐ Tobacco ☐ White Flour

PAST MEDICAL HISTORY (*Check all that apply. Please include dates***)**

☐ AIDS/HIV
☐ Alcoholism
☐ Allergies
☐ Appendicitis
☐ Arteriosclerosis
☐ Asthma
☐ Cancer
☐ Chicken Pox
☐ Diabetes
☐ Emphysema
☐ Epilepsy
☐ Goiter
☐ Gout
☐ Heart Disease
☐ Hepatitis
☐ Herpes
☐ High Blood Pressure
☐ Measles
☐ Multiple Sclerosis
☐ Mumps
☐ Pacemaker
☐ Pleurisy
☐ Pneumonia
☐ Polio
☐ Rheumatic Fever
☐ Scarlet Fever
☐ Seizures
☐ Stroke
☐ Surgery (*list)*
_____
_____
☐ Thyroid Disorders
☐ Major Traumas (*car, fall, etc. –list*)
_____
_____
☐ Tuberculosis
☐ Typhoid Fever
☐ Ulcers
☐ Venereal Disease
☐ Whooping Cough
☐ Other (*specify*)
_____
_____
_____

FAMILY MEDICAL HISTORY

☐ Alcoholism ☐ Asthma ☐ Diabetes ☐ High Blood Pressure ☐ Stroke
☐ Allergies ☐ Cancer ☐ Heart Disease ☐ Seizures

Notes:_____

GENERAL

☐ Poor appetite
☐ Heavy appetite
☐ Change in appetite
☐ Cravings _____
☐ Strong thirst (*cold/hot drinks*)
☐ Recent weight loss/gain
☐ Poor sleep
☐ Heavy sleep
☐ Dream-disturbed sleep
☐ Insomnia
☐ Fatigue
☐ Bodily heaviness
☐ Poor circulation
☐ Cold hands
☐ Cold feet or legs
☐ Cold lower back
☐ Cold abdomen
☐ Chills
☐ Fevers
☐ Tremors
☐ Night sweats
☐ Sweat easily
☐ Vertigo/dizziness

☐ Peculiar tastes/smells _____ ☐ Sudden energy drop at _____ (*time*) ☐ Bleed or bruise easily (*where*)
_____

SKIN AND HAIR

- ☐ Acne/Pimples
- ☐ Change in hair/skin texture
- ☐ Dandruff
- ☐ Eczema
- ☐ Fungal infections
- ☐ Hair loss
- ☐ Hives
- ☐ Itching
- ☐ Psoriasis
- ☐ Purpura
- ☐ Rashes
- ☐ Recent moles
- ☐ Ulceration

HEAD, EYES, EARS, NOSE, THROAT

- ☐ Concussions
- ☐ Dizziness
- ☐ Facial pain
- ☐ Headaches (*where and when*) _____
- ☐ Migraines
- ☐ Blurry vision
- ☐ Cataracts
- ☐ Color blindness
- ☐ Eye pain
- ☐ Eye strain
- ☐ Eyes sensitive to light
- ☐ Glasses
- ☐ Glaucoma
- ☐ Itchy eyes
- ☐ Night blindness
- ☐ Poor vision
- ☐ Red eyes
- ☐ Spots in front of eyes
- ☐ Earaches
- ☐ Poor hearing
- ☐ Ringing in ears
- ☐ Nose bleeds
- ☐ Sinus problems
- ☐ Copious saliva
- ☐ Dry mouth
- ☐ Dry throat
- ☐ Enlarged thyroid
- ☐ Excessive phlegm (*color*) _____
- ☐ Grinding teeth
- ☐ Gum problems
- ☐ Jaw clicks
- ☐ Lumps in throat
- ☐ Recurrent sore throats _____ per month
- ☐ Sores on lips or tongue
- ☐ Swollen glands
- ☐ Teeth problems

CARDIOVASCULAR

- ☐ Blood clots
- ☐ Chest pain
- ☐ Cold hands/feet
- ☐ Difficulty breathing
- ☐ Fainting
- ☐ High blood pressure
- ☐ Irregular heartbeat
- ☐ Low blood pressure
- ☐ Phlebitis
- ☐ Swelling in hands/feet
- ☐ Tachycardia

RESPIRATORY

- ☐ Asthma wheezing
- ☐ Bronchitis
- ☐ Cough: wet – dry; thick – thin (*circle*)
- ☐ Coughing blood
- ☐ Difficulty breathing when lying down
- ☐ Pain with deep inhalation
- ☐ Pneumonia
- ☐ Shortness of breath
- ☐ Tight chest

GASTROINTESTINAL

- ☐ Acid regurgitation
- ☐ Anal fissures
- ☐ Bad breath
- ☐ Belching
- ☐ Black stools
- ☐ Bloating
- ☐ Blood in stools
- ☐ Burning anus
- ☐ Constipation
- ☐ Diarrhea
- ☐ Gas
- ☐ Hemorrhoids
- ☐ Hiccup
- ☐ Indigestion
- ☐ Intestinal pain or cramping
- ☐ Itchy anus
- ☐ Mucus
- ☐ Nausea
- ☐ Rectal pain
- ☐ Vomiting

How often do you move your bowels? _____ times a day

Color of stool _____ Texture _____ Shape _____ Does stool float? ☐ Yes ☐ No

GENITO-URINARY

- ☐ Frequent urination
- ☐ Pain on urination
- ☐ Urgent urination
- ☐ Incomplete urination
- ☐ Decrease in flow
- ☐ Unable to hold urine
- ☐ Blood in urine
- ☐ Bedwetting
- ☐ Kidney stones
- ☐ Increased libido
- ☐ Decreased libido
- ☐ Sores on genitals
- ☐ Venereal disease

Color of urine: ☐ clear ☐ dark yellow ☐ light yellow Density of urine: ☐ thick ☐ medium ☐ watery

How many times a day do you urinate?_____ ☐ Wake up to urinate? How often _____ /night; time _____

MUSCULOSKELETAL

- ☐ Back pain (*where*) _____
- ☐ Foot/ankle pain
- ☐ Hand/wrist pain
- ☐ Hip pain
- ☐ Knee pain
- ☐ Limited range of motion _____
- ☐ Limited use _____
- ☐ Muscle pain
- ☐ Rib pain
- ☐ Shoulder pain

NEUROPSYCHOLOGICAL

- ☐ Abuse survivor
- ☐ Anxiety
- ☐ Bad temper
- ☐ Concussion_____
- ☐ Depression
- ☐ Dizziness
- ☐ Easily stressed
- ☐ Numbness (*where*)_____
- ☐ Irritability
- ☐ Loss of balance
- ☐ Poor coordination
- ☐ Poor memory
- ☐ Seeing a therapist
- ☐ Seizures
- ☐ Tics

PREGNANCY AND GYNECOLOGY

- ☐ Age at first menses _____
- ☐ PMS
- ☐ Painful periods
- ☐ Irregular periods
- ☐ Periods: ☐ heavy ☐ light
- ☐ Last menses _____
- ☐ Duration of flow _____ (*days*)
- ☐ Clots
- ☐ Breast lumps
- ☐ Menopause _____ (*age onset*)
- ☐ Changes in body/psyche prior to menstruation _____
- ☐ Number of pregnancies _____
- ☐ Number of births _____
- ☐ Premature births _____
- ☐ Miscarriages _____
- ☐ Abortions _____
- ☐ Vaginal discharge (*color*) _____
- ☐ Vaginal odors

Length of cycle _____ Last PAP _____

Do you practice birth control? _____ If so, what type? _____ For how long? _____

MALE SECTION

- ☐ Impotence
- ☐ Night urination
- ☐ Nocturnal emission
- ☐ Premature ejaculation
- ☐ Prostatitis
- ☐ Testicle pain
- ☐ Vasectomy