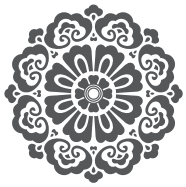

Lifted Heart

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HEALTH HISTORY

Please complete as thoroughly as possible. All questions play a role in harmonizing the bodymindspirit even if they seem unrelated to your condition. Thank you for your honesty.
All information is strictly confidential.

Name_____ email_____

Address_____ City_____

State____ Zip Code_____ (✓ preferred contact) Cell_____

Home phone _____Work phone _____

Date of birth ___/____/_____ Age_____ Gender ____ Height _____ Weight _____

Occupation_____ Feelings about work _____

_____

Relationship Status _____ Feelings about relationship _____

_____

Reason(s) for seeking acupuncture treatment. Please rank in order of significance to you:

1. _____ 2. _____

3._____ Other: _____

Does anything make it better or worse? _____

Emergency Contact Name _____ Number _____

Name & Address of Physician _____

Telephone Number _____ Treated for_____

Medications _____

_____

Herbs and Supplements _____

Do you eat 3 meals a day? _____. Please list meals & times for a typical day:

Breakfast _____at _____

Lunch _____ at _____

Dinner _____ at _____

Snacks _____ at _____

Do you have food allergies or sensitivities? Please describe. _____

_____

Do you crave foods? _____ Please circle: SALTY SWEET STARCHES

PROTEIN CHOCOLATE COFFEE FRIED SPICY

Do you take artificial sweeteners? _____ Smoke cigarettes? _____ Other drugs? _____

What type of exercise do you get? _____ Frequency? _____

How would you describe your overall physical health?_____

Mental and emotional health? _____ Spiritual health?_____

Do you commonly any of these emotions? Please circle all that apply:

JOY ANGER ANXIETY WORRY GRIEF SADDNESS FEAR

FRUSTRATION SYMPATHY MOOD-SWINGS Other _____

Is anything missing from life for you? _____

How was your childhood health? _____ Trauma? _____

Please describe any major conditions_____

Hospital visits / stays and dates _____

Please indicate any significant medical histories for your family members:

Mother _____

Father _____

Siblings _____

Children, (please list ages)_____

Please circle any symptoms you experience:

Low Energy / Fatigue Any particular time of day or night? _____

Shortness of Breath / Catch Colds Easily / Allergies Describe _____

Increased / Decreased Appetite / Weight Gain / Loss Amt _____ Period of Time_____

Dizziness / Floating Spots in Vision Field / Brittle Nails

Hot / Cold Body Temperature / Cold / Numb / Tingling / Sweaty Hands / Feet

Overly Thirsty / No thirst / Not able to quench thirst / Prefer Hot / Cold Drinks

Sweating Easily / No Sweating / Sticky / Oily / Profuse / Foul Odor Perspiration

Anxiety / Palpitations / Restlessness / Confusion / Forgetfulness / Absent Minded

Cough / Sinus Congestion / Dry Mouth / Dry Throat / Dry Nose / Dry Skin

Sneezing / Headaches Describe _____

Typical Sleep is _____ Hours per night from _____ to _____ Normal / Poor / Good

Difficult Falling Asleep / Staying Asleep / Wake with Nightmares / Frequent Dreaming

Easily Bruise / Hemorrhoids / Pensive / Over-Thinking / Worry

Abdominal Bloating / Gas / Gurgling Noise in Intestines / Fatigue After Eating

Loose / Constipated / Incomplete / Difficult / Diarrhea Stool Type

Blood / Mucus / Undigested Food / Foul Smelling / Burning Stool

General Heavy Feeling in Body / Mental Heaviness / Sluggishness / Fogginess

Swollen Hands / Feet / Joints / Snoring / Nausea / Chest Congestion

Burning Sensation After Eating / Large Appetite / Bad Breath / Acid Regurgitation

Ulcers / Belching / Hiccoughs / Stomach Pain / Vomiting / Heartburn / Mouth Sores

High / Low pitched Ringing in Ears / Muscle Twitches / Spasms
Chest Pain / Tightness in Chest / Neck Tension / Bitter Taste in Mouth / Irritable

Anger Easily / Depressed Feelings / Frustration / Sexually Transmitted Disease _____

Seizures / Convulsions / Skin Rashes / Alcohol Consumption _____

Eyes which are: Itchy / Bloodshot / Dry / Watery / Gritty / Blurred / Near or Far Sighted

Frequent Cavities / Easily Broken Bones / Sore Knees / Cold Knees / Weak Knees

Low Back Pain / Memory Problems / Excessive Hair Loss / Kidney Stones / UTIs

Wake to Urinate / Lack of Bladder Control / Fear or Sense of Doom / Easily Startled

Urination is: Normal Color / Dark Yellow / Clear / Reddish / Cloudy / Scanty / Profuse

Strong Odor / Burning / Painful / Discharge / Urgent / Frequent

Libido is: Normal / Very Low / Non Existent / Very High

MEN: Swellings / Testicular Pain / Impotence / Premature Ejaculation / Cold or Numbness

Other concerns _____

WOMEN: Age 1st menses _____Last Menses Date _____ Cycle Length? _____

Regular? _____ Pregnant? _____ Wanting to become pregnant?_____ Pregnancies _____

Number of Children ____ Miscarriages ____ Terminations ____ Difficulty Conceiving _____

Vaginal Discharge: Severe / Normal / Yellow / White / Itching / Burning / Foul Odor

Bleeding Between Periods / Missed Periods / Skipped Periods / Long / Short Periods

PMS: Nausea / Vomiting / Water Retention / Breast Swelling / Tenderness / Bloating

Gas / Diarrhea / Migraines / Dull Pain / Sharp Pains / Cramping in Lower Abdomen

Food Cravings / Depression / Headaches / Irritability / Anxiety / Other _____

Please describe your menstrual period in terms of color, amount and consistency of flow…

Day 1 _____ Day 2 _____ Day 3 _____

Day 4 _____ Day 5 _____ Day 6 _____

Other comments _____

_____

_____