points of health

Health History

Name_____Date_____

Phone (home)_____Phone (work)_____

email address_____SS#_____

Address_____City/State/Zip_____

Age_____Birth date_____Height_____Weight_____M/F_____

Marital Status_____Occupation_____

Employers Name_____

Employers Address_____

Personal Physician_____

Date of last physical exam_____

Emergency contact/Relationship_____Phone_____

Referred by/How did you find out about us?_____

Have you received Traditional Chinese Medicine or Naturopathic therapies in the past?_____

If so, with whom?_____

MAJOR COMPLAINT, INJURY OR ILLNESS

_____
_____
_____

Describe when the injury or symptoms started

_____
_____
_____

Have you ever had this condition, or similar condition, in the past? Yes No

Have you ever received treatment for this condition? Yes No If yes, when?_____

By whom?_____What was the diagnosis?_____

What improves this condition/injury?_____

What makes it worse?_____

What Doctors are you currently working with?_____

If suggested, is it permissible for us to contact these Doctors regarding your case_____Yes_____No

PERSONAL HEALTH HISTORY: Please check all that are appropriate.

__Adverse reaction to medical treatment

__Allergies

__Anemia

__Arthritis or Rheumatism

__Alcoholism

__Artificial heart valve or joints

__Asthma

__Bleeding Disorder

__Blood Disease

__Cancer or Tumor

__Chemical Dependency

__Depression

__Diabetes

__Drug Addiction

__Eating Disorder

__Gout

__Headaches

__Heart disease or pacemaker

__Hemophilia

__Hepatitis or Liver disorder

__Herpes

__High Blood Pressure

__Kidney Disorder

__Low Blood Pressure

__Mental Disorders

__Musculo-Skeletal Disorder

__Organ Transplant

__Osteoarthritis

__Pain

__Respiratory Disorder

__Rheumatic Fever

__Sciatica

__ Seasonal Affective Disorder

__Seizures/Epilepsy

__Skin Disorders

__Special Diet

__Spinal Problems

__Stomach or Intestinal Disorder

__Stroke

__Thyroid Disease

__Transfusion (before March 1985)

__Ulcer

__Urinary Tract Infection

__Other_____

MEDICATIONS & SUPPLEMENTS

Please list medications (including over the counter), that you are currently taking with dosage, doctor who prescribed them and last visit to doctor:

_____

_____

_____

Are you allergic to any medications?

_____

MAJOR HOSPITALIZATIONS

1st Hospitalization: year_____Illness_____Hospital City/State_____

2nd Hospitalization: year_____Illness_____Hospital City/State_____

3rd Hospitalization: year_____Illness_____Hospital City/State_____

Any complications during your birth?_____

Do you have scars from surgery? Yes No If yes, Where?_____

FAMILY MEDICAL HISTORY: Please check all that are part of your family history.

__Allergies

__Alcoholism

__Anemia

__Arthritis

__Alzheimers Disease

__Cancer

__Chemical Dependency

__Depression

__Diabetes

__Drug Addiction

__Eating Disorder

__Emphysema

__Genetic Disorder

__Glaucoma

__High Blood Pressure/Low Blood Pressure

__Infertility

__Kidney Disease/ Bladder Disease

__Learning Disabilities

__Liver Disease

__Mental Illness

__Migraine Headaches

__Obesity

__Osteoarthritis

__Seizures/Epilepsy

__Stroke

__Suicide

__Tuberculosis

__Ulcers

__Other_____

Please check the treatments with which you are most comfortable

__Acupuncture

__Western Herbal Medicine

__Movement Therapy/Qigong

__Womens Annual Exam (Naturopathic)

__Detoxification/Cleansing

__Nutritional Counseling

__Physical medicine/Massage

__Vitamin & Mineral Supplementation

__Lab work/Exams

__Facial Rejuvenation

__Chinese Herbal Medicine

__Energetic Treatment

__Relaxation Techniques

__Fertility Support

__Acne Treatment

Health History

LIFESTYLE:

__Coffee __Soft Drinks __Alcohol

__Cigarettes __Black Tea __Recreational Drugs

__Sugar __Salt __Stress Scale 1 2 3 4 5 6 7 8 9 10

In which areas of your life are you satisfied?

__Your Family __Your Relationships __Your Work __Your Spiritual Life __Your Health __Financial Security

Exercise:

__Never __Little __Moderate __Heavy

What type of exercise do you do?_____

Emotions:

__Happy __Worry __Easily Irritated __Difficulty Making Decisions __Lack of Joy

__Angry __Sad/Grief __In a Hurry __Cry Easily

__Fearful __Anxiety/Dread __Over thinking/Worry __History of Depression

Diet:

__Standard American __Vegetarian __Vegan __Low Carbohydrate

__Low Fat __Whole Foods __Other_____

Do you eat three meals a day? Yes No Do you eat at regular hours? Yes No

Appetite:

__Up and Down __Poor __Good __Constant Hunger __Loss of Taste

Thirst:

__Strong Thirst __Thirst with no desire to drink __No Thirst __Prefer Cold Drinks __Prefer Hot Drinks

Weight:

__Normal __Under Weight __Overweight __Recent Weight Gain __Recent Weight Loss

Energy:

__Up and down __Low __Excess __Low after eating __Tired in the afternoon

__Wake up tired __Normal

Body Temperature:

__Warm Natured __Flushed Face __Cold Natured

__Warm Palms and Warm Soles __Cold Hands and Feet __Feel Warm in late Afternoon or Night

Perspiration:

__Very Little __Easily __Palms __Feet

__Night Sweats __Profuse __Bad Smell __Without exertion

__Normal

Gastrointestinal:

__Indigestion __Heartburn __Excess Belching __Bad Breath __Bloating

__Gas/Flatulence __Bitter taste in mouth __Ulcers __Nausea/Vomiting __Gallstones

__Lack of appetite __Diarrhea __Distention/ __Difficulty with Fatty food __Loose stool

__Constipation __Excessive Appetite __Black Stool __Hemrrhoids __Abdominal Cramps

__Mucus in stool __Parasites __Burning Anus __Use of Laxatives __Recent use of antibiotics

__Other_____

Urination;

__Pain on Urination __Urgency __Frequent Urination __Blood in Urine __Decreased Flow

__Dribbling __Kidney Stones __Kidney Infection __Cloudy __Strong Smell

__Scanty __Unable to hold urine

__Other_____

Sleep:

__Awake easily __Tired after sleep __Lots of dreams __Nightmares ___Difficulty falling asleep

__Sleep too much __Restless

How many hours of sleep do you prefer?_____

How many hours of sleep do you actually get?_____

Head:

__Dizziness __Vertigo __Poor Balance __Motion Sickness

__Poor Memory __Faints Easily __Migraines __General Headaches

__Frontal/Sinus Headaches __Back of Head/Occipital Headaches __Temple Headaches __Other_____

Ears, Eyes, Nose & Throat:

__Contacts/Glasses __Spots in line of vision __Poor Night Vision __Night Blindness

__Color Blindness __Eye Pain/Strain __Cataracts __Glaucoma

__Eye Dryness __Discharge from eyes __Excess tearing __Dry

__Itchy __Poor Hearing __Ringing in the Ears __Ear Aches

__Discharge from Ear __Nose Bleeds __Sinus Congestion __Nasal Mucus

__Sinusitis __Hay Fever/Allergies __Sneeze Frequently __Loss of Smell

__Sore Throat __Hoarseness __Teeth Grinding __Feel Lump in Throat

__Thyroid Problems __Swollen Glands __Teeth Problems __Gum Problems

__Other_____

Skin & Hair:

__Rashes __Itching __Eczema __Oily

__Hives __Change in Hair or Skin __Pimples __Bruise Easily

__Cuts Heal Slowly __Yellow Skin __Boils __Clammy

__Loss of Hair __Dandruff __Unusual Body Odor

__Other_____

Cardiovascular:

__High Blood Pressure __Low Blood Pressure __Diagnosed Heart Problems __Palpitations

__High Cholesterol __Heart Murmur __Irregular Heart Beat __History of Anemia

__Blood Clots __Swelling of Feet __Swelling of Hands __Bruise Easily

__Other Heart or Blood Vessel Problems_____

Respiratory:

__Shortness of Breath __Cough __Pain with Deep Breath __Chest Pain

__Asthma/Wheezing __Difficulty Inhaling __Difficulty Exhaling __Chest Tightness

__Difficulty Breathing when Lying Down __Bronchitis __Sighing Frequently

__Cough with Blood __Pneumonia __Phlegm in Chest __Dry Feeling in Chest

Musculoskeletal:

__Neck Pain __Shoulder Pain __Low Back Pain __Mid Back Pain

__Elbow Pain __ Hand/Wrist Pain __Hip Pain __Sciatica

__Knee Pain __Side(flank) Pain __Foot/Ankle Pain __Muscle Pain

__Muscle Weakness __Arthritis __Numbness __Nerve Pain

__Other_____

(Women Only) Pregnancy & Gynecology:

__Premature Births	__Miscarriages	__Abortions	__Heavy Periods
__Light Periods	__Painful Periods	__Irregular Cycle	__Clotting during Period
__PMS	__Painful Breasts	__Unusual Vaginal Discharge	__Postcoital Bleeding
__Nipple Discharge	__Water Retention	__Abdominal Bloating	__Back Ache
__Spotting between Cycles	__Hot Flashes	__Vaginal Dryness	__Painful Intercourse

How long are your menstrual cycles?_____

Date of Last pap smear?_____

Do you use birth control?_____What type & for how long?_____

Are you, or might you be, pregnant? Yes No

Total number of pregnancies_____Total number of births_____

Have you used Assisted Reproductive Techniques in the past?_____

Have you had pregnancy or childbirth complications?_____

Are you having any menopausal symptoms?_____

Do you have regular breast exams?_____How Regular?_____

(Men Only) Men's Health:

__Prostate problems	__Decreased Urination Flow	__Impotence	__Reduced Sex Drive
__Seminal Emissions	__Genital Pain	__Pain or Burning During Urination	

Other _____

Are there any other health concerns that you would like to discuss?_____