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CONFIDENTIAL HEALTH HISTORY FORM

Name_____ Today's Date_____

Address_____ Daytime Phone_____

_____ Evening Phone_____

Birthdate_____ Age_____ HT_____ WT_____

Occupation_____ Relationship status_____

Emergency Contact:

Name_____ Number_____ Relationship_____

Have you been treated with Oriental Medicine before?_____

Please list all medications taken within the last 30 days_____

_____

_____

Main condition you would like help with:_____

_____

When did this condition begin? (be specific as possible)_____

_____

_____

If you have been given a diagnosis for this condition, what is it?_____

_____

To what extent does this condition interfere with your daily life? (work, sleep, relationships)

_____

_____

What kinds of treatment have you tried?_____

_____

_____

What makes the condition better?_____

_____

What makes the condition worse?_____

_____

Is your condition…? ☐ Getting worse ☐ Constant ☐ Comes and goes

Past Medical History: circle all that apply

AIDS/HIV	Diabetes	Jaundice
Alcoholism	Epilepsy	Kidney/Bladder Trouble
Anemia	Gallstones	Pneumonia
Anxiety	Gout	Seizures
Arthritis	Heart Disease	Stroke
Asthma	Hepatitis	Thyroid Disorder
Cancer	Herpes: oral genital	Tuberculosis
Chronic Fatigue/Fibromyalgia	High Blood Pressure	Other
Depression		

Family History: has a family member had one of the above?

Father:_____

Mother:_____

Siblings:_____

Energy level highest (best time of day)_____

Lowest (worst time of day)_____

List any surgeries/major traumas (car accident, falls…) and dates:

_____

_____

Do you exercise?_____ Type?_____ Frequency?_____

List all scars from accidents or surgeries_____

_____

Smoking History_____

Dietary Restrictions_____

Food Cravings_____

Herbs & Supplements_____

_____

Frequency of intake and amounts

Alcohol_____ Coffee_____ Tobacco_____

Recreational Drugs_____

Describe your home life:_____

_____

_____

_____

Describe your work life:_____

_____

_____

What is important to you?_____

_____

_____

How would you describe yourself?_____

_____

_____

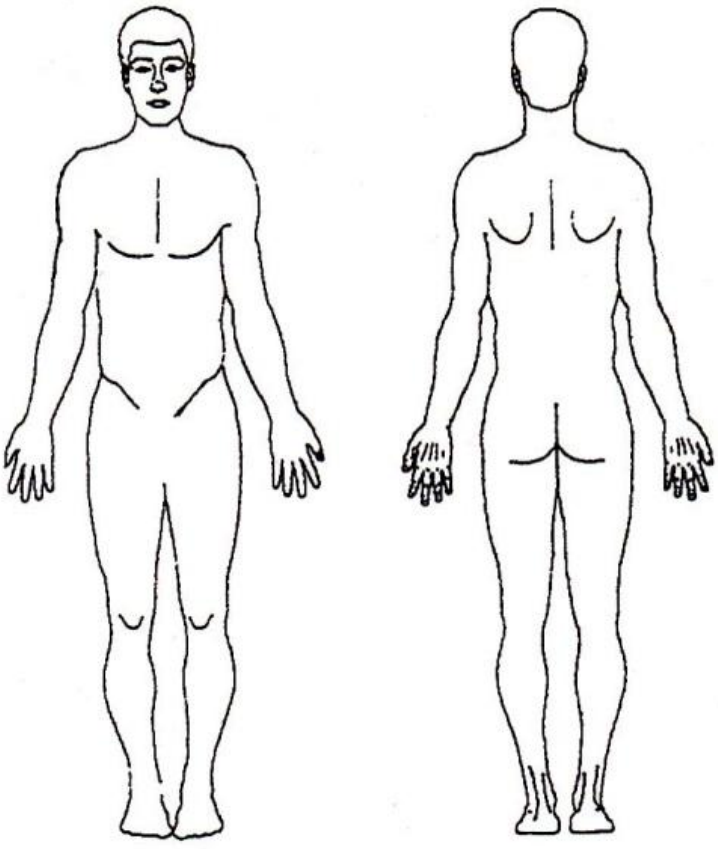
I will know the treatment is working when?_____

Please mark the following items **ONLY** if they are severe or occur frequently:

☐ Dislike heat	☐ Swellings or lumps	☐ Palpitations
☐ Dislike cold	Where?	☐ Feels like something's stuck
☐ Often feel warm	☐ Bruise easily	in throat
☐ Often feel cold	☐ Wounds heal slowly	☐ More energized at night
☐ Cold hands/feet	☐ Limbs feel heavy	☐ Feel tired
☐ Dizzy or spacy		

Musculoskeletal

Mark an X where you have pain or other issues:



Describe type of pain/discomfort:_____

_____

☐ Spasms/tremors? Where?_____

☐ Numbness/tingling? Where?_____

☐ Paralysis? Where?_____

☐ Lack of strength? Where? _____

☐ Joint swelling/pain/stiffness? Where?_____

Head and Face ☐ Hearing trouble ☐ Discharge from ears ☐ Ear pain

☐ Ringing in ear high/low pitch? ☐ Floaters ☐ Dry eyes

☐ Blurred vision ☐ Spots in eyes ☐ Dental problems ☐ Hair loss

Headaches (please circle) back of head/side of head/forehead/top of head

Other_____

Appetite & Digestion ☐ Always hungry ☐ Poor appetite ☐ Appetite keeps changing

☐ Feel tired/weak/irritable if a meal is missed ☐ Nausea ☐ Vomiting ☐ Belching/burping

☐ Rarely thirsty ☐ Prefer cold drinks ☐ Prefer hot drinks ☐ Overweight ☐ Bad breath

☐ Thin/can't gain weight ☐ Sudden weight gain/loss ☐ Trouble digesting oily food

☐ Prefer extra salt on food ☐ Ulcers ☐ Bitter taste in mouth. ☐ Sour taste in mouth

☐ Heartburn ☐ Lower bowel gas (farting) ☐ Sores in mouth, tongue, lips

☐ Stomach cramps/pain ☐ Stomach feels full/bloated ☐ Frequently thirsty

☐ Specific food cravings for what?_____

☐ Food allergies. To what?_____

☐ Other digestive concerns or problems_____

Nutrition

Types of food you normally eat_____

Types of snacks you normally eat_____

Do you…? ☐ Skip breakfast ☐ Eat a hearty breakfast

How many meals a day do you eat?_____When is your biggest meal?_____

Do you eat when you are worried or rushed ☐ Yes ☐ No

How many glasses of water per day do you drink? ☐ Filtered? ☐ Bottled? ☐ Tap?

What time is your last meal?_____

Sleep

☐ Fall asleep but wake during night what time?_____How many times?_____

Time it generally takes you to fall asleep_____

☐ Sleep but don't feel rested in the morning ☐ Wake up too early ☐ Hard to wake up

☐ Frequent dreams or nightmares ☐ Like to sleep in the daytime

Bowel Movements ☐ Loose stool ☐ Pebbly stools (deer pellets) ☐ Constipation

☐ Diarrhea ☐ Blood in stool ☐ Constipation alternating with loose stools

☐ Mucous in stool ☐ Stools have foul odor ☐ Fibrous material in stool

Number bowel movements/day_____Color of stool_____

Urination ☐ Frequent ☐ Painful ☐ Burning ☐ Scanty urine ☐ Clear

☐ Strong odor ☐ Cloudy ☐ Trouble starting/stopping urine flow ☐ Trouble holding urine

Color or urine: ☐ Pale ☐ Dark ☐ Orange

☐ Nighttime urination how many times/night?_____

Sweat ☐ Normally ☐ Rarely ☐ Easily/excessively ☐ Night sweats

☐ Perspire only on head ☐ Alternating chills & fever ☐ Afternoon flushes or fevers

☐ Day sweats when not exercising ☐ Hot/warm palms of hands or soles of feet

Respiratory

☐ Nose clogged or runs color_____

☐ Sinus problems ☐ Difficulty breathing ☐ Wheezing ☐ Mucus rattles when breathing

☐ Short of breath: ☐ at rest ☐ with activity ☐ Trouble breathing at night

☐ Pain/pressure in chest ☐ Persistent cough ☐ Cough blood ☐ Dry cough

☐ Coughing phlegm: color_____

☐ Bronchitis Number of colds per year_____ ☐ Sore throat ☐ Hoarse

☐ Difficulty swallowing ☐ Jaw problems ☐ Swollen tongue

☐ Skin problems (itchy/clammy/burning)

What type?_____Where?_____

(Circle) rashes/warts/moles/cysts/boils

Where?_____Any changes?_____

Females

☐ Pregnant Last monthly period_____Last PAP smear_____

Last breast exam_____Form of birth control: none/pill/other_____

Age began menstrual cycle_____ Age stopped_____

☐ Menstrual pain ☐ Low back pain ☐ Irregular cycle ☐ Miss periods

☐ Clotting ☐ Heavy bleeding ☐ Light scanty bleeding

☐ Pale blood ☐ Dark blood ☐ Watery blood

☐ Water retention ☐ Mood changes ☐ Painful breasts ☐ Hot flashes

Food cravings what?_____

Discharges: ☐ Yellow ☐ White ☐ Thick ☐ Odor

☐ Watery ☐ Itchy Other_____

☐ Low sex drive ☐ Excessive sex drive

Number of pregnancies_____ Number of Cesareans_____

Number of miscarriages_____ Number of abortions_____

Males

☐ Pain or burning during urination ☐ Premature ejaculation ☐ Prostate trouble

☐ Low sex drive ☐ Excessive sex drive ☐ Impotence ☐ Painful ejaculation

☐ Seminal emissions ☐ Discharges color_____

Is there anything else you would like me to know about you?