

# Healthy Living Acupuncture PLLC

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## Patient Health History

Name: \_\_\_\_\_ Today's Date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
(first) (middle) (last)

Address: \_\_\_\_\_

Phone: (home) \_\_\_\_\_ (cell) \_\_\_\_\_ Email: \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_\_ Marital status: S M D W

*Successful health care and preventative medicine are only possible when the practitioner has a complete understanding of the patient physically, mentally and emotionally. Please complete this questionnaire as thoroughly as possible. Thank you.*

1. When and where did you last receive health care? \_\_\_\_\_

Who is your Primary Care Physician? \_\_\_\_\_

2. Please identify the health concerns that have brought you here today, in order of importance. Please include any significant illnesses that you have had or currently have (Autoimmune Disease, Heart Disease, HIV/AIDS, Cancer, Diabetes, Hepatitis, Seizures, Other).

**Condition**

**How does this affect you & what treatment(s) have you tried?**

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

4. \_\_\_\_\_

3. Please list any foods, drugs, or medications you are hypersensitive or allergic to (please include reaction):

\_\_\_\_\_  
\_\_\_\_\_

4. Please list any medications (prescribed and over-the-counter), vitamins, and supplements you are currently taking:

\_\_\_\_\_  
\_\_\_\_\_

5. Do you have any reason to believe you may be pregnant? Y N If so, how far along are you? \_\_\_\_\_

**6. Family History:**

Father

Mother

Brothers

Sisters

Spouse

Children

**Check** those applicable:

Age (if living)

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Health (G=Good, P=Poor)

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Cancer

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Diabetes

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Heart Disease

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

High Blood Pressure

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Stroke

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Mental Illness

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Asthma/Hay fever/Hives

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Kidney Disease

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Age (at death)

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Cause of Death

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

7. **Height:** \_\_\_\_\_ **Weight:** Currently: \_\_\_\_\_ Past Maximum: \_\_\_\_\_ When? \_\_\_\_\_

8. **Blood Pressure:** What was your most recent blood pressure reading? \_\_\_\_\_/\_\_\_\_\_ When was this reading taken? \_\_\_\_\_

9. **Childhood Illness** (please circle any that you have had):

Scarlet Fever

Diphtheria

Rheumatic Fever

Mumps

Measles

German Measles

Chicken Pox

10. **Immunizations** (please circle any that you have had):

Polio

Tetanus

Rubella/Mumps/Rubella

Pertussis

Diphtheria

Hib

Hepatitis B

Others: \_\_\_\_\_

11. **Hospitalizations and Surgeries:**

Reason

When

Reason

When

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

12. **X-Rays/CAT Scans/MRI's/NMR's/Special Studies:**

Reason

When

Reason

When

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**FOR THE FOLLOWING SECTION: Please CIRCLE any that you're CURRENTLY experiencing, and UNDERLINE any that you've experienced in the past.**

**13. Mental/Emotional:** Mood Swings Nervousness Anxiety Depression Difficulty Focusing Poor Memory  
PTSD ADHD Seasonal Affective Disorder Other (please describe) \_\_\_\_\_

**14. Immune System:** Fatigue Slow Wound Healing Chronic Infections Recurring Colds/Flus Eczema  
Chronic Fatigue Syndrome Fibromyalgia Multiple Chemical Sensitivities Seasonal Allergies

**15. Head/Eye/Ear/Nose/Throat:** Eye Pain/Strain Burning Eyes Glaucoma Glasses/Contacts Dryness  
Impaired Hearing Ear Ringing: High Pitch/Low Pitch Earaches Sinus Congestion Nosebleeds  
Bleeding Gums Frequent Sore Throats Teeth Grinding TMJ/Jaw pain Cavities Gum Disease  
Headaches (top of head, temples, occipital, eye, left or right side?) \_\_\_\_\_

**16. Respiratory:** Pneumonia Recurrent Bronchitis Frequent Colds Shortness of Breath Emphysema  
Persistent Cough Pleurisy Asthma Hay Fever Tuberculosis/Coughing Blood COPD  
Other Respiratory Problems: \_\_\_\_\_

**17. Cardiovascular:** Heart Disease High Cholesterol Chest Pain Swollen Ankles High Blood Pressure  
Low Blood Pressure Easy Bruising Palpitations Stroke Pacemaker Heart Murmurs Anemia  
AFIB Varicose Veins Dizziness Blood Clots Difficulty Clotting Other \_\_\_\_\_

**18. Gastrointestinal:** Ulcers Appetite: Low/High Nausea/Vomiting Stomach Pain Gas Bloating  
Heartburn/Acid Reflux Belching Hemorrhoids Gallstones Irregular Bowel: Loose? Hard?  
Hepatitis B or C Abdominal Pain Ulcerative Colitis Constipation Diarrhea Blood in stool

**19. Genito-Urinary:** Kidney Disease Painful/Burning Urination Frequent UTI Frequent Urination Daytime  
Frequent Urination at Night Heavy Flow Dribbling Incontinence Kidney Stones Blood in Urine

**20. Female Reproductive:** Irregular Cycles Heavy/Light Periods Clotting Bleeding Between Cycles  
Painful Periods Mid-cycle Pain Endometriosis Genital Sores Vaginal Discharge Vaginal Dryness  
Difficulty Conceiving Nipple Discharge Breast Lumps/Tenderness Low Libido  
PMS (please indicate symptoms, ie irritable, sad, pain, headaches, etc) \_\_\_\_\_

Menopausal Symptoms (please indicate symptoms, ie. Hot flashes, night sweats, insomnia, poor memory, brain fog, etc)  
\_\_\_\_\_

**21. Menstrual/Birthing History:**

1. Age of First Menses: \_\_\_\_\_ 2. # Days of Bleeding: \_\_\_\_\_ 3. Length of Cycle: \_\_\_\_\_ 4. Birth Control \_\_\_\_\_  
5. # Pregnancies: \_\_\_\_\_ 6. # Live Births: \_\_\_\_\_ 7. # Miscarriages: \_\_\_\_\_ 8. # Abortions: \_\_\_\_\_

**22. Male Reproductive:** ED/Sexual Difficulties    Enlarged Prostate    Low Libido    Testicular Pain/Swelling  
Penile Discharge    Prostate Cancer    Genital sores

**23. Musculoskeletal:** Neck/Shoulder Pain    Muscle Spasms/Cramps    Arm Pain    Upper Back Pain  
Mid Back Pain    Low Back Pain    Leg Pain    Other Joint Pain (where?): \_\_\_\_\_

**24. Neurologic:** Vertigo/Dizziness    Paralysis    Numbness/Tingling    Loss of Balance    Seizures    Tremors

**25. Endocrine:** Hypoglycemia    Hyperthyroid or Hypothyroid    Diabetes Type I or II    Night Sweats  
Feel Hot or Cold    High Thirst    Easy Sweating    Absence of Sweating    High Hunger    Hair Loss  
Cold Hands/Feet    Weight Gain/Loss

**26. Lifestyle:**

1. Briefly describe **Dietary habits** (# meals/day, foods you avoid)  
\_\_\_\_\_
2. Do you have particular **Food cravings**? Flavors? \_\_\_\_\_
3. Do you tend to *feel* more **Hot** or **Cold**? In any particular part of your body? \_\_\_\_\_
4. **Exercise**? How often/what type? \_\_\_\_\_
5. Spiritual practice? \_\_\_\_\_
6. **Sleep:** # hours \_\_\_\_\_ Wake rested?    Y    N    Difficulty falling asleep?    Y    N  
Difficulty staying asleep?    Y    N    Vivid dreams?    Y    N    Night Sweats?    Y    N
7. Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_ Hrs/Week: \_\_\_\_\_  
Do you enjoy your work?    Y    N    Why/Why not \_\_\_\_\_
8. Nicotine/Alcohol/Caffeine Use:  
\_\_\_\_\_
9. Have you experienced any major traumas?    Y    N    Please explain:  
\_\_\_\_\_  
\_\_\_\_\_
10. How many glasses of non-caffeinated, non-carbonated beverages do you drink per day? \_\_\_\_\_
11. Interests and hobbies: \_\_\_\_\_
12. How did you hear about this acupuncture clinic? \_\_\_\_\_

By signing below, I verify that the above information is correct to the best of my knowledge.	
Patient Name _____	Date _____
Patient Signature _____	