

# HEALTH HISTORY

Date: \_\_\_ / \_\_\_ / \_\_\_

|                                  |  |                                |       |   |        |      |           |
|----------------------------------|--|--------------------------------|-------|---|--------|------|-----------|
| Name:                            |  |                                |       | Sex:  |        | Age: |           |
| Address:                         |  |                                | City: |   | State: |      | Zip Code: |
| Home Phone #:                    |  | Other Phone #: Work Cell Other |       | Email:  |        |      |           |
| Date of Birth:                   |  | Emergency Contact              |       | Emergency Contact Phone Number  |        |      |           |
| How did you hear of our clinic?: |  |                                |       | Have you been treated by Acupuncture or Oriental Medicine Before?<br><input type="checkbox"/> No <input type="checkbox"/> Yes ___ / ___ / ___ |        |      |           |

## MAIN COMPLAINTS

Please write in your top 3 health complaints / concerns in order of importance to you. Circle the items that make it better or worse and mark on the scale from 1-10 the severity of the condition (1=no symptoms, 10=worst ever)

↓

**1** \_\_\_\_\_

When did this start? \_\_\_\_\_ ago

Heat makes it:    better    no change    worse

Cold makes it:    Better    no change    worse

Damp weather:    Better    no change    worse

Exercise / Activity: better    no change    worse

1|-----| 10

**2** \_\_\_\_\_

When did this start? \_\_\_\_\_ ago

Heat makes it:    better    no change    worse

Cold makes it:    better    no change    worse

Damp weather:    better    no change    worse

Exercise / Activity: better    no change    worse

1|-----| 10

**3** \_\_\_\_\_

When did this start? \_\_\_\_\_ ago

Heat makes it:    better    no change    worse

Cold makes it:    better    no change    worse

Damp weather:    better    no change    worse

Exercise / Activity: better    no change    worse

1|-----| 10

## HEALTH HISTORY

Check the box if you have / had the condition and note the year it started.  
Check the box if there is a family history of the condition.

|                     | YOU                      | Year  | FAMILY                   |                    | YOU                      | Year  | FAMILY                   |
|---------------------|--------------------------|-------|--------------------------|--------------------|--------------------------|-------|--------------------------|
| Cancer type(s)?     | <input type="checkbox"/> | _____ | <input type="checkbox"/> | Osteoporosis       | <input type="checkbox"/> | _____ | <input type="checkbox"/> |
| Diabetes            | <input type="checkbox"/> | _____ | <input type="checkbox"/> | Herpes             | <input type="checkbox"/> | _____ | <input type="checkbox"/> |
| Hepatitis           | <input type="checkbox"/> | _____ | <input type="checkbox"/> | AIDS / HIV         | <input type="checkbox"/> | _____ | <input type="checkbox"/> |
| High Blood Pressure | <input type="checkbox"/> | _____ | <input type="checkbox"/> | Other STD          | <input type="checkbox"/> | _____ | <input type="checkbox"/> |
| Heart Disease       | <input type="checkbox"/> | _____ | <input type="checkbox"/> | Rheumatic Fever    | <input type="checkbox"/> | _____ | <input type="checkbox"/> |
| Stroke              | <input type="checkbox"/> | _____ | <input type="checkbox"/> | Alcoholism         | <input type="checkbox"/> | _____ | <input type="checkbox"/> |
| Seizure Disorder    | <input type="checkbox"/> | _____ | <input type="checkbox"/> | Allergies type(s)? | <input type="checkbox"/> | _____ | <input type="checkbox"/> |
| Thyroid Disease     | <input type="checkbox"/> | _____ | <input type="checkbox"/> | Mental Illness     | <input type="checkbox"/> | _____ | <input type="checkbox"/> |
| Asthma              | <input type="checkbox"/> | _____ | <input type="checkbox"/> | Kidney Disease     | <input type="checkbox"/> | _____ | <input type="checkbox"/> |
| Pacemaker           | <input type="checkbox"/> | _____ | <input type="checkbox"/> | Anemia             | <input type="checkbox"/> | _____ | <input type="checkbox"/> |

## HABITS

Amount / Week    If Quit, Year?

Coffee / Tea \_\_\_\_\_

Soda \_\_\_\_\_

Tobacco \_\_\_\_\_

Alcohol \_\_\_\_\_

Drugs \_\_\_\_\_

## EXERCISE

Do you exercise regularly?     Yes     No

If so, what and how often:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## DIET

Do you have a special diet now or in the past? (vegetarian, vegan, raw, Atkins, etc.)

Describe w/ dates: \_\_\_\_\_

## MEDICATIONS

Please note what medications, herbs or supplements that you take regularly

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## INJURIES & SURGERIES

Please note what happened to what body area and when it occurred (incl. dental)

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_