Acupuncture Northwest
Patient Health History

Please note that all information is confidential.

Name: birth date: / / today's date: / /

In Case of Emergency Contact:

Relationship & Phone:

Physician: Phone:

How did you hear about us?

Thank you for taking the time to fill out this form as completely as possible. Successful health care and preventative medicine are only possible when the practitioner has a complete understanding of the patient's physical, mental and emotional state.

What brings you here today?

What is the reason for your visit today?

_____

_____

How, when and where did this condition begin

_____

_____

What types of treatments have you tried, if any?

_____

_____

How does this condition impair your daily activities?

_____

_____

Please list your main health problems you would like to address in order of importance:

1. _____
2. _____
3. _____

Your Medical History:

Surgeries, Major Illnesses, Hospitalizations, and Major Accidents (include dates):

_____

_____

_____

Health and emotional state throughout your childhood:

_____

_____

Please list any medications/vitamins/supplements you are currently taking, as well as, medications you have taken in the past:

Medications	Reason	How Long

Please circle any of the following that are a part of your life

Mental Illness	Diabetes	Hepatitis	HIV
Seizures	Cancer	Heart Disease	Asthma
Allergies	Fatigue	Parasites	Kidney Stones
Stroke	Arthritis	Ulcers	Herpes
High Blood Pressure	Venereal Disease	Osteoporosis	AIDS
Rheumatic Fever	Thyroid Problems	Mononucleosis	Gall Stones

Other _____

Lifestyle:

What is your daily diet like?

Breakfast: _____

Lunch: _____

Dinner: _____

Snack: _____

What is your occupation?

_____

Do you enjoy your work? Yes No Why? _____

Number of hours per week you spend working: _____

Do you Exercise? Yes No Number of times/ week: _____

Type of exercise: _____

Do you have trouble falling asleep? Yes No

Time to bed: _____ Time to rise: _____

How many hours of sleep do you get per night? _____

Are you rested in the morning? Yes No

Do you wake during the night? Yes No

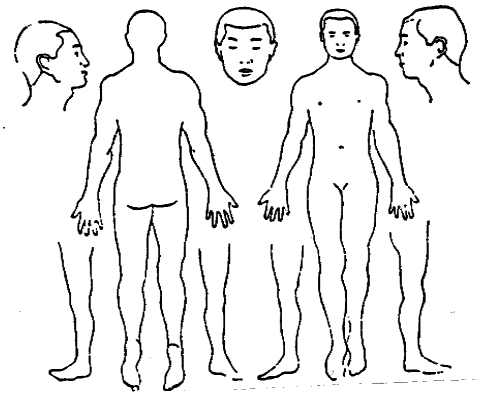
Do you often awake more than 1x/ night to urinate? Yes No

How is your home Life?

_____

_____

Please mark all areas of pain on the diagram:



Systems Review (please circle all that apply):

0 = never 1 = rarely 2= occasionally 3= frequently 4 = always

0	1	2	3	4	spontaneous sweat	0	1	2	3	4	fatigue
0	1	2	3	4	allergies	0	1	2	3	4	catch colds easily
0	1	2	3	4	asthma	0	1	2	3	4	shortness of breath
0	1	2	3	4	general weakness	0	1	2	3	4	cough
0	1	2	3	4	dry nose/mouth/skin/throat	0	1	2	3	4	nasal discharge
0	1	2	3	4	feel worse after exercise	0	1	2	3	4	sinus congestion

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0	1	2	3	4	nightmares						
0	1	2	3	4	feel heart beating	0	1	2	3	4	chest pain
0	1	2	3	4	insomnia	0	1	2	3	4	feel low in spirits
0	1	2	3	4	sores on tip of tongue	0	1	2	3	4	headaches
0	1	2	3	4	anxiety	0	1	2	3	4	restlessness
0	1	2	3	4	chest pain traveling to shoulder						

overall body temperature high med low

0 1 2 3 4	DIGESTIVE PROBLEMS	0 1 2 3 4	PRONE TO WORRY
0 1 2 3 4	LOW APPETITE	0 1 2 3 4	RAVENOUS APPETITE
0 1 2 3 4	LOOSE STOOLS	0 1 2 3 4	ACID REFLUX
0 1 2 3 4	MOUTH SORES	0 1 2 3 4	FATIGUE AFTER EATING
0 1 2 3 4	GAS/BLOATING AFTER FOOD	0 1 2 3 4	BRUISE EASILY
0 1 2 3 4	GUMS (BLEEDING/SWOLLEN)	0 1 2 3 4	THIRST
0 1 2 3 4	ORGAN PROLAPSED (DIAGNOSED)	0 1 2 3 4	BELCHING/VOMITING
0 1 2 3 4	OFTEN SICK OR HAVE ALLERGIES	0 1 2 3 4	CRAVE SWEETS
0 1 2 3 4	TIRED AFTER MEALS	0 1 2 3 4	PAIN WORSE W/ RAIN
0 1 2 3 4	FIBROCYSTIC BREASTS	0 1 2 3 4	OVERWEIGHT
0 1 2 3 4	ACNE	0 1 2 3 4	HEAVY SENSATION
0 1 2 3 4	FOUL SMELLING STOOLS	0 1 2 3 4	DIZZINESS
0 1 2 3 4	DRY MOUTH/THROAT	0 1 2 3 4	EXCESSIVE SWEATING
0 1 2 3 4	THIRSTY FOR COLD DRINKS	0 1 2 3 4	RED ACNE
0 1 2 3 4	DO YOU FEEL WARM	0 1 2 3 4	SHORT MENSES CYCLE
0 1 2 3 4	SYMPTOMS WORSE WITH STRESS	0 1 2 3 4	IRRITABLE
0 1 2 3 4	BREAST TENDERNESS	0 1 2 3 4	NUMB EXTREMITIES
0 1 2 3 4	TIGHT FEELING IN CHEST	0 1 2 3 4	DRY EYES
0 1 2 3 4	ALT. DIARRHEA/CONSTIPATION	0 1 2 3 4	EAR RINGING
0 1 2 3 4	MUSCLE TWITCHES/SPASMS	0 1 2 3 4	ANGER EASILY
0 1 2 3 4	NECK/SHOULDER TENSION	0 1 2 3 4	RED EYES
0 1 2 3 4	FEEL BETTER AFTER EXERCISE		
0 1 2 3 4	DRY SKIN	0 1 2 3 4	SCANTY MENSES
0 1 2 3 4	BRITTLE NAILS	0 1 2 3 4	LATE MENSES
0 1 2 3 4	DIZZINESS/LIGHTHEADED	0 1 2 3 4	SEE FLOATERS
0 1 2 3 4	LOOSENING OR THINNING HAIR		
0 1 2 3 4	PREMATURE GREY HAIR	0 1 2 3 4	MORNING DIARRHEA
0 1 2 3 4	SORE, COLD OR WEAK KNEES	0 1 2 3 4	FEEL COLD
0 1 2 3 4	LOW BACK PAIN	0 1 2 3 4	EDEMA
0 1 2 3 4	FREQUENT URINATION	0 1 2 3 4	URINARY INCONTINENCE
0 1 2 3 4	NIGHT SWEATS	0 1 2 3 4	EAR PROBLEMS
0 1 2 3 4	HOT FLASHES	0 1 2 3 4	PAIN BETTER WITH HEAT
0 1 2 3 4	FACE FLUSH	YES NO	IMPAIRED MEMORY
0 1 2 3 4	HEAT IN PALMS OR SOLES	YES NO	INFERTILITY
0 1 2 3 4	AFTERNOON FEVER	YES NO	HAIR LOSS
		HIGH NORMAL LOW	LIBIDO

URINATION: PLEASE CIRCLE ANY OF THE FOLLOWING SYMPTOMS YOU ARE CURRENTLY EXPERIENCING

BURNING URGENT RETENTION SCANTY

PROFUSE DRIBBLING UP TO URINATE MORE THAN 1X A NIGHT

BOWEL MOVEMENT:

FREQUENCY: WHEN? _____ FEELS COMPLETE? YES NO

CONSISTENCY: WELL-FORMED HARD LOOSE ALTERNATES

STOOLS: UNDIGESTED FOOD BLOOD MUCUS

_____

_____

Women Only:

At what age did you get your first period: _____

Date of last menstrual cycle: _____

Are you currently on birth control? Yes No if yes, what kind? _____

Are you pregnant now? Yes No

# of days from the start of one period to the start of the next: _____

Average number of days of flow: _____

For the following please circle:

Are your menstrual cycles spaced regularly? Yes No

Flow is: Light . Normal . Heavy

Color is: . light red . red . dark red . purple . Brown

Do you have blood clots? Yes No

Does your period cause you pain or cramping? Yes No

When? Before . During . After Period

Do you have breast lumps? Yes No

Do you experience any of the following before your period each month?

Water retention Breast tenderness or swelling Mental depression

Irritability Food cravings Migraines Other_____

Of pregnancies _____ # of abortions_____

Of live births _____ # of miscarriages_____

Are you in menopause? Yes No When? _____

If you are experiencing menopausal symptoms, please describe:

_____

_____

Men Only:

Have you been diagnosed with prostate problems? Yes No

Do you experience premature ejaculation? Yes No

Do you have problems with Impotence? Yes No

Have you been diagnosed with Infertility? Yes No

Diseases/ Disorders:

_____

_____

Chronic or continuing illnesses: _____

Nicotine/alcohol/caffeine use: _____

Have you ever experienced any major traumas? Y / N

Please explain: _____

How many glasses of water do you drink per day? _____

Interests and hobbies: _____

Is there anything else I should know?_____

_____

Signature: _____

Date: _____