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History Form

1. Please complete the enclosed medical history forms, and bring them with you to your first appointment.

2. We require a minimum 24 hour notice of cancellation if you are unable to keep your appointment.

IMPORTANT: Please complete this document as thoroughly as possible. All information is strictly confidential.

Date: _____

Name (last, first, MI):_____

Address: _____

City: _____ State:_____ Zip Code:_____

Phone Number:_____

Email:_____

Age: _____ Date of Birth (MM/DD/YY): _____ Sex: Female/ Male

Marital Status (circle one): Married/ Single/ Divorced/ Widowed

Occupation: _____

Primary Health Care Physician/MD: _____

Emergency Contact #1: _____ Contact Number:_____

Emergency Contact #2: _____ Contact Number: _____

How did you hear about our office:

_____

If referred, please give the name of who referred you:

_____

Have you ever had acupuncture before: Y/N

If yes, from whom:_____

For what:_____

Have you been treated by a Homeopath before? Y/N

If yes, from whom:_____

For what:_____

Do you have a pacemaker or other implantable device: Yes No

MAJOR COMPLAINTS, IN ORDER OF IMPORTANCE

1. _____ 2. _____
3. _____ 4. _____
5. _____ 6. _____

How do these conditions impair your daily activities? _____

_____

_____

PAST MEDICAL HISTORY

Check any that you have had in the past:

❑ Diabetes ❑ Heart Disease ❑ Asthma ❑ Jaundice ❑ Syphilis

❑ Meningitis ❑ Epilepsy ❑ Paralysis ❑ Other Lung Illness

❑ Allergies ❑ CVA (stroke) ❑ Pneumonia ❑ Gonorrhea ❑ Measles

❑ HIV ❑ High Fever ❑ Cancer ❑ Other Liver Illness

❑ Glaucoma ❑ Vein Condition ❑ Tuberculosis ❑ Mumps ❑ Chicken Pox

❑ Polio ❑ Hepatitis ❑ Migraines ❑ Other Heart Illness

❑ Rheumatic Fever ❑ Thyroid Disorder ❑ Emphysema

❑ Bleeding Tendency ❑ Nervous Disorder ❑ Mononucleosis

❑ Multiple Sclerosis ❑ High Blood Pressure ❑ Other Kidney Illness

❑ Other _____

Please list any major injuries you may have had in the past: _____

_____

What vaccinations have you had: _____ Tetanus- Date:_____

_____Shingles- Date:_____ _____Pneumonia- Date:_____

_____Meningitis- Date:_____ _____Gardisil- Dates:_____

_____Chicken Pox -Date:_____ _____Hepatitis B- Dates:_____

_____Hepatitis A- Dates:_____ _____MMR- Dates:_____

_____Influenza – Date:_____

Did you have any adverse reactions to them? Please list information below:

_____

Past Surgical History

Please list any major surgeries you may have had in the past: _____

_____

If you are over 50, have you had a colonoscopy? Y / N If so, when:_____

Medications and Supplements

Please list all prescribed and over the counter medications, supplements, and vitamins you are currently taking routinely. Indicate the dosage and reason for taking, as well. Write on the back of the sheets if needed.

Name _____ dosage _____ purpose _____

Name _____ dosage _____ purpose _____

Name _____ dosage _____ purpose _____

Name _____ dosage _____ purpose _____

Name _____ dosage _____ purpose _____

If additional medications, please list on the back of this form.

Allergies

Are you allergic to any medications : Y / N

Are you allergic to any supplements/herbs: Y / N

Are you allergic to any food: Y / N

Are you allergic anything in the environment: Y / N

Are you allergic to anything else: Y / N

If so, please list:_____

Family History

Relative	Alive	Health Conditions/Cause of Death
Mother	Y / N	
Father	Y / N	
MGF	Y / N	
MGM	Y / N	
PGF	Y / N	
PGM	Y / N	
Sister	Y / N	
Brother	Y / N	
Other	Y / N	

Diet & Lifestyle

Do you drink caffeine: Y / N how much: _____ coffee / tea / soda/ energy drinks

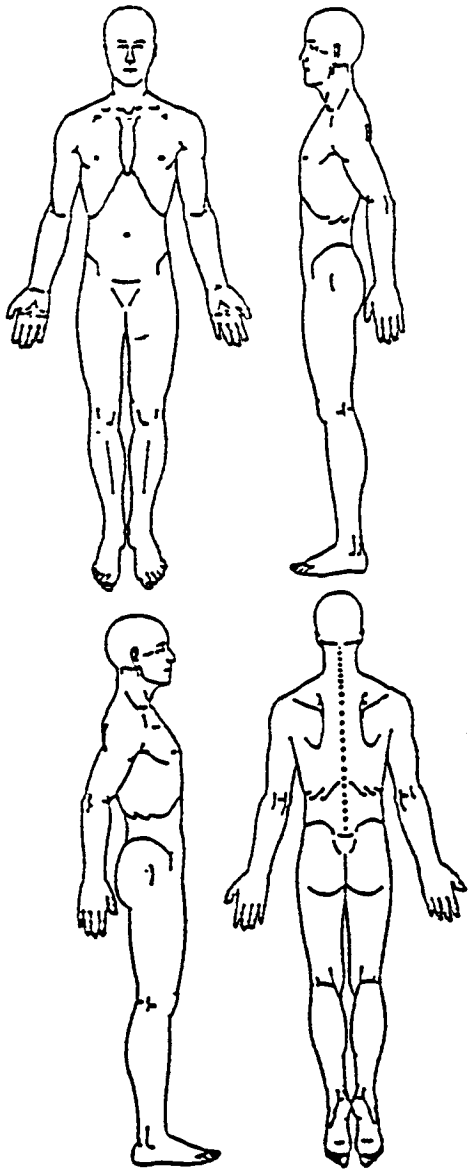
Do you drink alcohol: Y / N how much: _____

Do you smoke: Y / N how much: _____

Do you chew tobacco: Y / N how much: _____

Do you do recreational drugs: Y / N which ones: _____

Patient Profile Please clearly mark any areas of pain and any scars (please indicate which of the areas are scars)



Is the pain:

❑ Sharp ❑ Cramping ❑ Fixed ❑ Burning ❑ Dull

❑ Aching ❑ Moving ❑ Other:

Do the following improve the pain?

❑ Pressure ❑ Exercise ❑ Cold ❑ Heat ❑ Other:

Do the following worsen the pain?

❑ Pressure ❑ Cold ❑ Heat ❑ Other:

Please check the following that currently pertain to you (if you have symptoms in the following categories, it indicates that you have a problem with that organ's function):

OVERALL TEMPERATURE (Kidney Function)

❑ Sweaty feet ❑ Hot body temperature (sensation) ❑ Cold body temperature (sensation)

❑ Afternoon flushes ❑ Hot flashes any time of the day ❑ Heat in the hands, feet, and chest

❑ Night sweats ❑ Thirsty ❑ Perspire easily ❑ Lack of perspiration

❑ Take water to bed

OVERALL ENERGY (Lung, Kidney function)

❑ Shortness of breath ❑ Low energy ❑ Difficulty keeping eyes open in the daytime

❑ Feel worse after exercise ❑ General weakness ❑ Easily catch colds

OVERALL BLOOD (Liver, Spleen, Heart function)

❑ Dizziness ❑ See floating black spots

HEART FUNCTION

❑ Palpitations ❑ Anxiety ❑ Drink coffee (# of cups per week:_____)

❑ Sores on the tip of the tongue ❑ Restlessness ❑ Mental confusion

❑ Chest pain traveling to shoulder ❑ Frequent dreams ❑ Wake unrefreshed

LUNG FUNCTION

❑ Nasal Discharge (Color: _____) ❑ Allergies (To what?_____)

❑ Headache (Location: _____) ❑ Smoke cigarettes (# of cigarettes a day: ___)

❑ Cough ❑ Nose Bleeds ❑ Sinus Congestion ❑ Alternating fever and chills

❑ Dry Mouth ❑ Stiff neck ❑ Stiff shoulders ❑ Melancholy

❑ Sadness ❑ Dry throat ❑ Dry nose ❑ Dry skin

❑ Sore throat ❑ Difficulty breathing ❑ Sneezing ❑ Achy feeling

SPLEEN FUNCTION

❑ Low appetite ❑ Abrupt weight gain ❑ Abrupt weight loss ❑ Abdominal bloating

❑ Prolapsed organs (previously diagnosed, which organ? _____)

❑ Abdominal gas ❑ Gurgling noise in the stomach ❑ Fatigue after eating

❑ Easily bruised ❑ Hemorrhoids ❑ Pensive ❑ Worry

❑ Over-thinking

SPLEEN, STOMACH, LARGE INTESTINE, SMALL INTESTINE FUNCTION

❑ Loose ❑ Constipated ❑ Incomplete ❑ Diarrhea

❑ Blood in stools ❑ Mucous in stools ❑ Undigested food in stools

DAMPNESS TRAPPED IN THE BODY

❑ Mental heaviness ❑ Mental sluggishness ❑ Mental fogginess ❑ Snoring

❑ General sensation of heaviness in the body ❑ Swollen hands ❑ Swollen feet

❑ Swollen joints ❑ Chest congestion ❑ Nausea

STOMACH FUNCTION

❑ Large appetite ❑ Bad breath ❑ Mouth (canker) sores

❑ Heartburn ❑ Acid regurgitation ❑ Burning sensation after eating

❑ Ulcer (diagnosed) ❑ Belching ❑ Bleeding, swollen or painful gums

❑ Hiccups ❑ Stomach pain ❑ Vomiting

LIVER, GALLBLADDER FUNCTION

❑ Alternating diarrhea and constipation ❑ Headache at the top of the head

❑ Tight sensation in the chest ❑ Bitter taste in the mouth

❑ High-pitched ringing in the ears ❑ Gall stones (history or current)

❑ Frustration ❑ Depression ❑ Irritability ❑ Skin rashes

❑ Chest pain ❑ Anger easily ❑ Tingling sensation ❑ Numbness

❑ Muscle spasms ❑ Muscle twitching ❑ Muscle cramping ❑ Seizures

❑ Convulsions ❑ Lump in the throat ❑ Neck tension ❑ Drink alcohol

❑ Shoulder tension ❑ Limited Range-of-Motion, neck

❑ Limited Range-of-Motion, shoulder

❑ Sexually transmitted disease (Which? _____)

❑ Recreational drugs (Which? _____ , How much per week? _____)

❑ Frequently unable to adapt to stress (What causes the stress? _____)

EYES (Liver function)

❑ Itchy ❑ Bloodshot ❑ Hot ❑ Dry

❑ Watery ❑ Gritty ❑ Blurry vision ❑ Decreased night vision

❑ Near-sighted ❑ Far-sighted

KIDNEY, URINARY BLADDER FUNCTION

❑ Frequent cavities ❑ Sore knees ❑ Weak knees

❑ Cold sensation in the knees ❑ Low back pain ❑ Memory problems

❑ Excessive hair loss ❑ Kidney stones ❑ Low-pitched ringing the ears

❑ Bladder infections ❑ Easily broken bones ❑ Lack of bladder control

❑ Fear ❑ Easily startled ❑ Wake during the night twice to urinate

URINATION

❑ Normal color ❑ Dark yellow ❑ Clear ❑ Reddish

❑ Cloudy ❑ Scanty ❑ Profuse ❑ Strong color

❑ Burning ❑ Urgent ❑ Frequent ❑ Painful

❑ Discharge ❑ Difficult

LIBIDO

❑ Normal ❑ High ❑ Low

WOMEN ONLY

Regular menstrual cycle? ❑ Y ❑ N Number of children: _____ Age of first menstruation: _____
Average number of days of flow: _____ Vaginal discharge? ❑ Y ❑ N Pregnant? ❑ Y ❑ N
Number of pregnancies: _____ Age of menopause (if applicable): _____
Average number of days of entire cycle: _____ Bleeding between periods? ❑ Y ❑ N

Do you experience any of the following pre-menstrual syndromes?

❑ Nausea ❑ Food cravings ❑ Depression ❑ Vomiting

❑ Headaches ❑ Irritability ❑ Water retention ❑ Migraines

❑ Anxiety ❑ Breast swelling ❑ Breast tenderness

❑ Sharp pain, Where? _____

❑ Dull pain, Where? _____

Please fill out the following menstrual chart:	Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7
Color (normal, bright red, pale, rust, brown, dark, purple, other)							
Amount of Flow (normal, heavy, light)							
Pain/Cramps (location, dull, sharp, other)							
Clots (large, small, black, red, purple, other)							
Vomiting (check if yes)							
Nausea (check if yes)							
Other							

MEN ONLY

❑ Swollen testes ❑ Testicular pain ❑ Impotence

❑ Feeling of coldness or numbness in external genitalia

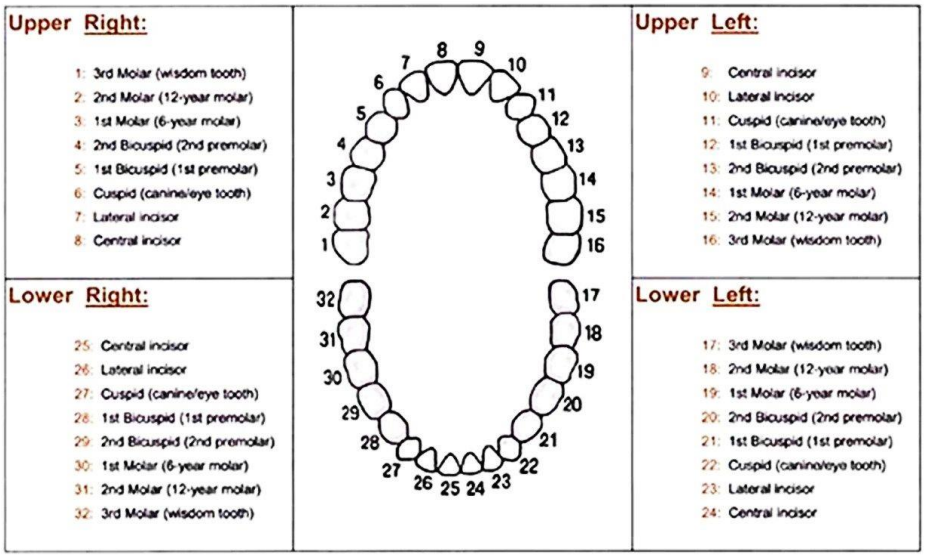
❑ Other _____

DENTAL HISTORY – Please Mark Tooth on Chart if Known Treatment

❑ Silver Fillings - S ❑ Crowns - C ❑ Root canals - R ❑ Dentures

❑ Pulled teeth - P ❑ Flouride Treatments ❑ Flouride Toothpaste

❑ Other treatments



TOXIN HISTORY

❑ Lead ❑ Mold ❑ Aluminum (deodorant or cookware)

❑ City Water ❑ Farm Chemicals ❑ Microwave Use ❑ Wifi at night

❑ Industrial Exposures

Age of home: