Family Wellness Acupuncture Inc.

CONFIDENTIAL PATIENT HEALTH HISTORY

Patient Name: _____ **Date of Birth:** _____

Chief Complaint(s) (Please provide as much information as possible)

Have you received any treatments? If so, what kind and for how long?

Previous hospitalizations, surgeries, serious illnesses (when, hospital, city, state)

Have you ever sustained an injury from an accident or other means? If so what and when?

Medications (include non-prescription, vitamins, supplements, etc.)

Please list all allergies (Food, Medicine, Seasonal, Other)

Other Complaints (Please provide as much information as possible)

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FAMILY MEDICAL HISTORY

	Age	Diseases	If deceased, cause of death
Father			
Mother			
Siblings			
Spouse			
Children			

PLEASE ADD A CHECK FOR ANY CONDITIONS YOU HAVE HAD OR CURRENTLY HAVE

ENDOCRINE
- ☐ Thyroid problems
- ☐ Heat or cold intolerance
- ☐ Fatigue
- ☐ Hypoglycemia
- ☐ Excess thirst or hunger
- ☐ Diabetes
- ☐ Seasonal depression

MENTAL/EMOTIONAL
- ☐ Mood swings/depression
- ☐ Eating disorder
- ☐ History of counseling
- ☐ Tension
- ☐ Anxiety or nervousness
- ☐ Considered suicide

IMMUNE
- ☐ Chronic fatigue syndrome
- ☐ Chronically swollen glands
- ☐ Chronic infections
- ☐ Frequent colds
- ☐ Auto-immune disease
- ☐ Allergies or hay fever

NEUROLOGIC
- ☐ Seizures
- ☐ Vertigo or dizziness
- ☐ Paralysis
- ☐ Muscle weakness
- ☐ Numbness or tingling
- ☐ Loss of balance
- ☐ Loss of memory

SKIN
- ☐ Rashes
- ☐ Color change
- ☐ Eczema
- ☐ Fungus
- ☐ Itching
- ☐ Acne or boils

HEAD
- ☐ Headaches
- ☐ Migraines
- ☐ Head Injury
- ☐ Jaw/TMJ problems

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RESPIRATORY

- ☐ Cough
- ☐ Pain on breathing
- ☐ Wheezing or asthma
- ☐ Shortness of breath
- ☐ Bronchitis
- ☐ Spitting up blood

NOSE AND SINUSES

- ☐ Stuffiness
- ☐ Nose Bleeds
- ☐ Hay fever
- ☐ Sinus problems
- ☐ Loss of smell
- ☐ Sinus headaches

EARS

- ☐ Impaired hearing
- ☐ Earaches
- ☐ Ringing

EYES

- ☐ Floaters or 'spots'
- ☐ Cataracts
- ☐ Blurriness
- ☐ Double Vision
- ☐ Glaucoma
- ☐ Near/Far sightedness
- ☐ Tearing or dryness
- ☐ Eye pain/strain
- ☐ Impaired vision

MUSCULOSKELETAL

- ☐ Joint pain
- ☐ Joint stiffness
- ☐ Arthritis
- ☐ Weakness
- ☐ Sciatica
- ☐ Broken bones
- ☐ Muscle pain
- ☐ Muscle spasm
- ☐ Osteoporosis

MOUTH AND THROAT

- ☐ Teeth grinding
- ☐ Hoarseness
- ☐ Copious saliva
- ☐ Dry mouth
- ☐ Gum problems
- ☐ Sore tongue/lips
- ☐ Sore throat
- ☐ Mouth sores

CARDOVASCULAR

- ☐ Heart disease
- ☐ Murmurs
- ☐ Chest pain
- ☐ Poor circulation
- ☐ Blood clots
- ☐ Deep leg pain
- ☐ Valvular problems
- ☐ Palpitations
- ☐ Easy bruising
- ☐ Anemia
- ☐ Varicose veins
- ☐ Fainting
- ☐ Swelling in ankles

URINARY/KIDNEY

- ☐ Pain on urination
- ☐ Increased frequency
- ☐ Frequency at night
- ☐ Kidney stones
- ☐ Infections
- ☐ Urine leakage

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REPRODUCTIVE

- ☐ Pain with intercourse
- ☐ Chlamydia
- ☐ Herpes
- ☐ Genital warts
- ☐ Discharge or sores
- ☐ Sexual difficulties
- ☐ Trouble conceiving

GASTROINTESTINAL

- ☐ Trouble swallowing
- ☐ Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Belching
- ☐ Passing gas
- ☐ Change in appetite
- ☐ Heartburn
- ☐ Ulcer
- ☐ Change in thirst
- ☐ Hemorrhoids
- ☐ Pain or cramps
- ☐ Black stool
- ☐ Blood in toilet

FEMALE ONLY

- _____ # of days of bleeding per cycle
- _____ Are cycles regular?
- _____ PMS
- _____ Length of cycle (days)
- _____ Bleeding between cycles
- _____ Discharge
- _____ Painful menses
- _____ Endometriosis
- _____ Menopause symptoms
- _____ Breast lumps or pain
- _____ Nipple discharge
- _____ Do you do self-breast exams?
- _____ Age of first menses
- _____ Clotting
- _____ Heavy menstruation
- _____ Last menstruation
- _____ Abnormal paps
- _____ Ovarian cysts
- _____ # of pregnancies
- _____ # of miscarriages
- _____ # of live births
- _____ # of abortions
- _____ Are you nursing

MALE ONLY

- _____ Hernias
- _____ Testicular mass
- _____ Prostate disease
- _____ Impotence
- _____ Testicular pain
- _____ Premature ejaculation

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HABITS

How many meals do you eat per day? What time do you eat each meal? (Please also list any known food intolerances)
How much water do you drink daily?
Do you drink coffee, tea, cola and or energy drinks?
Do you drink alcohol, use tobacco and or use recreational drugs?
Do you exercise? If yes, what kind, how often and how long?
Do you prefer cold, room temperature or hot drinks?
What time do you go to bed? (Please list how many hours per night)
How do you rate the quality of your sleep? Please list the factors contributing to your sleep rating.

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A FEW FINAL QUESTIONS:

How does your health condition affect your life on an ongoing basis?

How would your life be different if you didn't have this condition?

On a scale of 1-10, how committed are you to improving your state of health? (1 = least, 10 = most)

On a scale of 1-10, how much change are you willing to make at this time for improving your state of health? (1 = least, 10 = most)