



# 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? <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)

\_\_\_\_\_

\_\_\_\_\_