Patient Health History

Name:_____ Date:_____
Address:_____
City, State, Zip code _____

Phones: Home_____ Work:_____ Cell:_____
Email address:_____
Date of Birth:_____ Age:_____
Occupation:_____
Emergency contact:_____
Referred by:_____
Current Medications:_____

_____

_____

Are you/might you be currently pregnant/nursing?_____
Do you have any implants/pacemaker?_____

Treatment Goal(s)
What is the main condition you would like to address?

_____

_____

How does this affect your daily activities (sleeping, working, etc)?

_____

_____

When did this condition begin?_____
What diagnosis, if any, have you been given?_____
What treatments have you tried?_____
Other conditions you would like to address_____

_____

_____

WULF acupuncture

If you are experiencing **pain**, please complete the following;

Quality of pain: ___ sharp ___ stabbing ___ throbbing ___ dull
___ burning ___ cramping other_____
___ continuous ___ comes & goes
___ numbness ___ wakes you up at night

Do any of the following lessen the pain? ___ heat ___ cold
___ holding the area (pressure) ___ rest ___ stretching
___ gentle movement ___ vigorous exercise

Do any of the following worsen the pain? ___ heat ___ cold
___ pressure ___ rest (worse during sleep) ___ movement
___ sitting ___ walking ___ weather (rain, cold, wind)

Past Medical History

Check all that apply and indicate dates where applicable

___ Hepatitis ___ HIV / AIDS ___ Diabetes
___ Cancer ___ High Blood Pressure ___ Heart Disease
___ Surgery_____
Other significant medical condition:_____
Trauma/Accidents_____
Emotional trauma (divorce, etc):_____

Lifestyle

Do you exercise regularly?_____
Do you smoke? _____ If so, how much?_____
Do you drink alcohol? _____ If so, how much? _____
How much coffee/tea/soda do you drink per day?_____
How much water do your drink per day? _____
How often do you eat the following;

Vegetables_____ Candy_____ Dairy_____
Fruit _____ Chips _____ Artificial sweeteners:_____
Red meat _____ Fast food _____ Diet food/drinks:_____
Refined carbs (bread, pastries, cake, cookies, etc)_____
What supplements do you currently take? _____

_____

_____

Are you vegetarian?_____

Current Health Indicators

Height_____ Weight _____

Recent change in weight?_____

Body Temperature

- ___ Cold fingers
- ___ Cold hands
- ___ Cold arms
- ___ Cold toes
- ___ Cold feet
- ___ Cold legs
- ___ Feel cold all over
- ___ Feel hot all over
- ___ Feel hot in afternoon
- ___ Feel hot in face
- ___ Feel hot in hands
- ___ Feel hot in feet
- ___ Feel feverish
- ___ Thirsty
- ___ Sweaty at night
- ___ Thirsty at night
- ___ Hot flashes
- ___ Sweat easily
- ___ Lack of sweat
- ___ Take water to bed

Energy Level

- ___ Low energy
- ___ Low energy after exercise
- ___ Low energy at specific time of day. If so, when?_____
- ___ Shortness of breath
- ___ Sleepy during day
- ___ Lethargic
- ___ Reluctance to talk
- ___ Catch colds easily
- ___ Fatigue

Circulation/Blood

- ___ Dizzy
- ___ See floaters/spots
- ___ Numbness/tingling in extremities

Heart and Associated TCM Functions (TCM=Traditional Chinese Medicine)

- ___ Palpitations
- ___ Irregular heartbeat
- ___ Pacemaker
- ___ Insomnia
- ___ Poor sleep
- ___ Chest pain
- ___ Mental confusion
- ___ Sores on tip of tongue
- ___ Anxiety
- ___ Chest pain traveling to arm or shoulder
- ___ Restlessness

Lung and Associated TCM Functions

- ___ Nasal Discharge: Color_____ Thick or Thin____
- ___ Cough
- ___ Nose bleeds
- ___ Sinus congestion
- ___ Overall achy body
- ___ Sore throat
- ___ Allergies
- ___ Clear throat frequently
- ___ Headaches. If so, where & how often _____
- ___ Dry mouth
- ___ Dry throat
- ___ Dry nose
- ___ Stiff neck
- ___ Difficulty breathing
- ___ Smoke cigarettes
- ___ Sniffling/snorting
- ___ Dry skin
- ___ Fever & chills
- ___ Sneezing
- ___ Stiff shoulders
- ___ Feel sad
- ___ Melancholy

Spleen and Associated TCM Functions

___ Low appetite
___ Crave sweets
___ Abdominal bloating
___ Worry
___ Loose stools
___ Discomfort after BM
___ Blood in stool
___ Constipation
___ Abdominal gas
___ Gurgling stomach
___ Feel tired after eating
___ Over thinking
___ Urgent BMs
___ Undigested food in stool
___ Mucous in stool
___ Dry lips
___ Hemorrhoids
___ Bruise easily
___ Nose bleeds
___ Pensive
___ Diarrhea
___ Weight gain
___ Weight loss

Number of bowel movements per day (or per week)_____

___ Prolapsed organ. If so, which organ and when_____

Dampness

___ General feeling of heaviness in body
___ Mental sluggishness
___ Vaginal discharge
___ Nausea
___ Overweight
___ Mental fogginess
___ Swelling

Stomach and Associated TCM Functions

___ Heartburn
___ Pain after eating
___ Large appetite
___ Bad breath
___ Belching
___ Mouth sores (canker sores)
___ Bleeding, painful or swollen gums
___ Facial swelling/pain
___ Acne
___ Hiccups
___ Nausea/Vomiting
___ Acid regurgitation
___ Stomach pain

Liver/Gallbladder and Associated TCM Functions

___ Alternating diarrhea and constipation
___ Bitter taste in mouth
___ Anger easily
___ Frustration
___ Depression
___ Gall stones
___ Bad temper
___ Irritable
___ Lump in throat
___ Feel tense
___ High pitched ringing in ears
___ High stress level
___ Headaches
___ Heat in head/face
___ Muscle tension
___ Muscle twitches
___ Discomfort/tightness/tension around ribcage
___ Itch/pain genitals
___ Seizures/convulsions
___ Itchy skin/rashes
___ Sexually transmitted disease (Which?_____)

Eyes:

___ Itchy ___ Bloodshot ___ Dry ___ Watery ___ Eyes feel hot

Kidney and Associated TCM Functions

- ___ Low back pain/weakness
- ___ Cold sensation in low back
- ___ Wake at night to urinate
- ___ Bladder/Kidney/urinary infection
- ___ Lack of bladder control
- ___ Excessive hair loss/balding
- ___ Frequent broken bones
- ___ Libido: __Normal __High __ Low
- ___ Osteoporosis
- ___ Weak or sore knees
- ___ Cold sensation in knees
- ___ Kidney stones
- ___ Memory problems
- ___ Feel fearful
- ___ Easily startled
- ___ Frequent cavities
- ___ Kidney infections
- ___ Restless legs at night

Urination:

- ___ Normal color
- ___ Reddish
- ___ With blood
- ___ Dark yellow. If yes, do you take vitamins? _____
- ___ Clear
- ___ Cloudy
- ___ Scanty
- ___ Profuse
- ___ Frequent
- ___ Strong odor
- ___ Painful
- ___ Dribbling
- ___ Urgent
- ___ Difficult

Other _____

For Women Only

Are you currently pregnant? _____

Age at first period _____ Age at menopause _____

Number of pregnancies _____ Number of live births _____

Are you having or have you had difficulty conceiving? _____

Are your menses regular or irregular? _____

Is your flow heavy or light _____

How many days does your period last? _____

How many days between periods? _____

Other _____

Do you experience any of the following symptoms before or during your period?

- ___ Abdominal cramps
- ___ Breast tenderness/swelling
- ___ Depression
- ___ Dull pain
- ___ Food cravings
- ___ Headaches/Migraines
- ___ Moodiness
- ___ Sharp pain

For Men Only

Do you experience any of the following?

- ___ Swollen testes
- ___ Coldness or numbness in genitalia
- ___ Testicular pain
- ___ Impotence