

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 _____



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 you 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

<input type="checkbox"/> Cold fingers	<input type="checkbox"/> Feel hot all over	<input type="checkbox"/> Sweaty at night
<input type="checkbox"/> Cold hands	<input type="checkbox"/> Feel hot in afternoon	<input type="checkbox"/> Thirsty at night
<input type="checkbox"/> Cold arms	<input type="checkbox"/> Feel hot in face	<input type="checkbox"/> Hot flashes
<input type="checkbox"/> Cold toes	<input type="checkbox"/> Feel hot in hands	<input type="checkbox"/> Sweat easily
<input type="checkbox"/> Cold feet	<input type="checkbox"/> Feel hot in feet	<input type="checkbox"/> Lack of sweat
<input type="checkbox"/> Cold legs	<input type="checkbox"/> Feel feverish	<input type="checkbox"/> Take water
<input type="checkbox"/> Feel cold all over	<input type="checkbox"/> Thirsty	<input type="checkbox"/> to bed

Energy Level

<input type="checkbox"/> Low energy	<input type="checkbox"/> Low energy after exercise	
<input type="checkbox"/> Low energy at specific time of day. If so, when?	_____	
<input type="checkbox"/> Shortness of breath	<input type="checkbox"/> Sleepy during day	<input type="checkbox"/> Lethargic
<input type="checkbox"/> Reluctance to talk	<input type="checkbox"/> Catch colds easily	<input type="checkbox"/> Fatigue

Circulation/Blood

Dizzy See floaters/spots Numbness/tingling in extremities

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

<input type="checkbox"/> Palpitations	<input type="checkbox"/> Irregular heartbeat	<input type="checkbox"/> Pacemaker
<input type="checkbox"/> Insomnia	<input type="checkbox"/> Poor sleep	<input type="checkbox"/> Chest pain
<input type="checkbox"/> Mental confusion	<input type="checkbox"/> Sores on tip of tongue	<input type="checkbox"/> Anxiety
<input type="checkbox"/> Chest pain traveling to arm or shoulder		<input type="checkbox"/> Restlessness

Lung and Associated TCM Functions

<input type="checkbox"/> Nasal Discharge: Color _____		<input type="checkbox"/> Thick or Thin _____
<input type="checkbox"/> Cough	<input type="checkbox"/> Dry mouth	<input type="checkbox"/> Dry skin
<input type="checkbox"/> Nose bleeds	<input type="checkbox"/> Dry throat	<input type="checkbox"/> Fever & chills
<input type="checkbox"/> Sinus congestion	<input type="checkbox"/> Dry nose	<input type="checkbox"/> Sneezing
<input type="checkbox"/> Overall achy body	<input type="checkbox"/> Stiff neck	<input type="checkbox"/> Stiff shoulders
<input type="checkbox"/> Sore throat	<input type="checkbox"/> Difficulty breathing	<input type="checkbox"/> Feel sad
<input type="checkbox"/> Allergies	<input type="checkbox"/> Smoke cigarettes	<input type="checkbox"/> Melancholy
<input type="checkbox"/> Clear throat frequently	<input type="checkbox"/> Sniffing/snorting	
<input type="checkbox"/> Headaches. If so, where & how often _____		

Spleen and Associated TCM Functions

- | | | |
|--|---|--|
| <input type="checkbox"/> Low appetite | <input type="checkbox"/> Abdominal gas | <input type="checkbox"/> Hemorrhoids |
| <input type="checkbox"/> Crave sweets | <input type="checkbox"/> Gurgling stomach | <input type="checkbox"/> Bruise easily |
| <input type="checkbox"/> Abdominal bloating | <input type="checkbox"/> Feel tired after eating | <input type="checkbox"/> Nose bleeds |
| <input type="checkbox"/> Worry | <input type="checkbox"/> Over thinking | <input type="checkbox"/> Pensive |
| <input type="checkbox"/> Loose stools | <input type="checkbox"/> Urgent BMs | <input type="checkbox"/> Diarrhea |
| <input type="checkbox"/> Discomfort after BM | <input type="checkbox"/> Undigested food in stool | <input type="checkbox"/> Weight gain |
| <input type="checkbox"/> Blood in stool | <input type="checkbox"/> Mucous in stool | <input type="checkbox"/> Weight loss |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Dry lips | |

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

___ Prolapsed organ. If so, which organ and when _____

Dampness

- | | | |
|---|---|-----------------------------------|
| <input type="checkbox"/> General feeling of heaviness in body | <input type="checkbox"/> Mental fogginess | |
| <input type="checkbox"/> Mental sluggishness | <input type="checkbox"/> Nausea | <input type="checkbox"/> Swelling |
| <input type="checkbox"/> Vaginal discharge | <input type="checkbox"/> Overweight | |

Stomach and Associated TCM Functions

- | | | |
|--|--|---|
| <input type="checkbox"/> Heartburn | <input type="checkbox"/> Mouth sores (canker sores) | |
| <input type="checkbox"/> Pain after eating | <input type="checkbox"/> Bleeding, painful or swollen gums | |
| <input type="checkbox"/> Large appetite | <input type="checkbox"/> Facial swelling/pain | <input type="checkbox"/> Nausea/Vomiting |
| <input type="checkbox"/> Bad breath | <input type="checkbox"/> Acne | <input type="checkbox"/> Acid regurgitation |
| <input type="checkbox"/> Belching | <input type="checkbox"/> Hiccups | <input type="checkbox"/> Stomach pain |

Liver/Gallbladder and Associated TCM Functions

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

Eyes:

- Itchy Bloodshot Dry Watery Eyes feel hot

Kidney and Associated TCM Functions

- | | |
|---|--|
| <input type="checkbox"/> Low back pain/weakness | <input type="checkbox"/> Weak or sore knees |
| <input type="checkbox"/> Cold sensation in low back | <input type="checkbox"/> Cold sensation in knees |
| <input type="checkbox"/> Wake at night to urinate | <input type="checkbox"/> Kidney stones |
| <input type="checkbox"/> Bladder/Kidney/urinary infection | <input type="checkbox"/> Memory problems |
| <input type="checkbox"/> Lack of bladder control | <input type="checkbox"/> Feel fearful |
| <input type="checkbox"/> Excessive hair loss/balding | <input type="checkbox"/> Easily startled |
| <input type="checkbox"/> Frequent broken bones | <input type="checkbox"/> Frequent cavities |
| <input type="checkbox"/> Libido: <input type="checkbox"/> Normal <input type="checkbox"/> High <input type="checkbox"/> Low | <input type="checkbox"/> Kidney infections |
| <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Restless legs at night |

Urination:

- | | | |
|---|------------------------------------|--------------------------------------|
| <input type="checkbox"/> Normal color | <input type="checkbox"/> Reddish | <input type="checkbox"/> With blood |
| <input type="checkbox"/> Dark yellow. If yes, do you take vitamins? | _____ | |
| <input type="checkbox"/> Clear | <input type="checkbox"/> Cloudy | <input type="checkbox"/> Scanty |
| <input type="checkbox"/> Profuse | <input type="checkbox"/> Frequent | <input type="checkbox"/> Strong odor |
| <input type="checkbox"/> Painful | <input type="checkbox"/> Dribbling | <input type="checkbox"/> Urgent |
| <input type="checkbox"/> 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?

- | | |
|---|--|
| <input type="checkbox"/> Abdominal cramps | <input type="checkbox"/> Food cravings |
| <input type="checkbox"/> Breast tenderness/swelling | <input type="checkbox"/> Headaches/Migraines |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Moodiness |
| <input type="checkbox"/> Dull pain | <input type="checkbox"/> Sharp pain |

For Men Only

Do you experience any of the following?

- | | |
|--|--|
| <input type="checkbox"/> Swollen testes | <input type="checkbox"/> Testicular pain |
| <input type="checkbox"/> Coldness or numbness in genitalia | <input type="checkbox"/> Impotence |