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 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

Circlulation/Blood

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

Heart and Associated TCM Functions

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

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 fogginess
___ Mental sluggishness ___ Nausea ___ Swelling
___ Vaginal discharge ___ Overweight

Stomach and Associated TCM Functions

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

Liver/Gallbladder and Associated TCM Functions

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

Any other comments: _____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Your body talks to you. No one else can listen to your body for you.
To heal, listen to your body

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