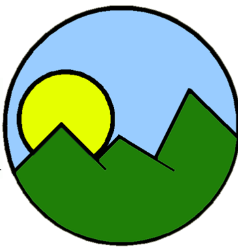
Old Mountain 针灸  老山 Health Center

Ancient Ways to Modern health

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Patient Health History

Name:____ Date:_______________

(First) (Middle) (Last)

Street Address:________________________ City:__________ State:______ Zip Code:__________

Telephone Number:________________ Email:____________________Date of Birth:__________

Gender:________ Marital Status:__________

Emergency Contact:__________ Telephone:________________ Relationship:______________

Successful health care is only possible when the practitioner has a thorough understanding of the patient physically, mentally, and emotionally. Please Complete the following questionnaire as thoroughly as possible.

1. Are you currently receiving health care? Y N If yes, where and from whom?________________
If no, when and where did you last receive health care?______________ For what reason?__________
2. Please identify the health concerns that have brought you to the clinic below:

Condition **Past Treatment**

a.____
b.____
c.____
d.____

4. Are you pregnant or is there any possibility you could be pregnant? Y N

5. Do you have any chronic infectious disease? Y N If yes, please explain:______________

6. Are you suffering from any chronic illnesses? Y N If yes, please explain:______________

7. **Significant diseases, injuries, accidents, hospitalizations, surgeries, X-Rays/CAT scans/MRI's/NMR's/etc**

Reason When

____
____
____
____
____
____
____

8. Please list any prescription medications, over-the-counter medications, vitamins, or supplements that you are currently taking and give your dosage:

____
____

9. Please list any foods, drugs, substances, or medications you are hypersensitive or allergic to

____

10. **Height**:___________**Weight**:_____________

11. Blood Pressure:What is your most recent blood pressure reading:______/______When?:___________

12. **Immunizations** (please circle any that you have had):

Polio Tetanus Measles/Mumps/Rubella Pertussis Diphtheria Hepatitis B Others:_______________________

13.

Family History:	Mother	Father	Brothers	Sisters
Age [if living]				
Health [G=good, P=poor]				
Age at death [if deceased]				
Cause of death				
Check off Family illnesses:	Mother	Father	Brothers	Sisters
Cancer				
Diabetes				
Heart Disease				
High Blood Pressure				
Stroke				
Mental Illness				

14. **Emotional** – please circle any that you experience currently

Mood Swings Depression Anxiety Mental Tension Past Traumas__________________________________

15. **Energy and Immunity** – please circle any that you experience currently

Fatigue Slow Wound Healing Chronic Infections Chronic Fatigue Syndrome Other: _________________

16. **Head, Eye, Ear, Nose & Throat** - please circle any that you experience currently

Ear Ringing Headaches Sinus Problems Frequent Sore Throat TMJ/Jaw Problems Hay Fever/Allergies

17. **Respiratory** - please circle any that you experience currently

Pneumonia Frequent Common Colds Difficulty Breathing Persistent Cough Asthma Other:_________

18. **Cardiovascular** - please circle any that you experience currently

Heart Disease Chest Pain High Blood Pressure Palpitations/Fluttering Other: _______________________

19. **Gastrointestinal** - please circle any that you experience currently

Nausea/Vomiting Epigastric or Abdominal Pain Heartburn Gallbladder Disease Liver Disease

Hemorrhoids Chronic Diarrhea Chronic Congestion Blood in Stool Other: ______________________

20. **Genito-Urinary Tract** - please circle any that you experience currently

Kidney Disease Painful Urination Blood in Urine Nighttime Urination Incontinence
Other:___________

21. **Female Reproductive** - please circle any that you experience currently

Irregular Cycles Bleeding Between Cycles Vaginal Discharge Premenstrual Problems

Menopausal Symptoms Pelvic Pain Infertility Other:_______________________

22. **Menstrual/Birthing History:**

# of Pregnancies:		# of Live Births:		# of Miscarriages:	
# of Days of Flow		# of Days in Cycle:		Type of Birth Control [if any]	

23. **Male Reproductive** - please circle any that you experience currently

Sexual Difficulties Prostrate Problems Other: _______________________________________

24. **Musculoskeletal** - please circle any that you experience currently

Neck/Shoulder Pain Muscle Spasms/Cramps Arm Pain Leg Pain Back Pain

Back Pain: [if so where] ___________________ Joint Pain [if so where] ________________________

25. **Neurological Problems** - please circle any that you experience currently

Vertigo/Dizziness Paralysis Numbness Loss of Balance Seizures Stroke Other: ______________

26. **Endocrine and Metabolic Disorders** - please circle any that you experience currently

Hypothyroidism Hypoglycemia Hyperthyroidism Diabetes Mellitus Night Sweats Other: __________

27. **Other** - please circle any that you experience currently

Anemia Cancer Rashes Eczema/Hives Cold Hands/Feet Other:_______________________________

28. **Lifestyle** -
a. Please indicate typical food and beverage intake:

Breakfast	Lunch	Dinner	Snacks

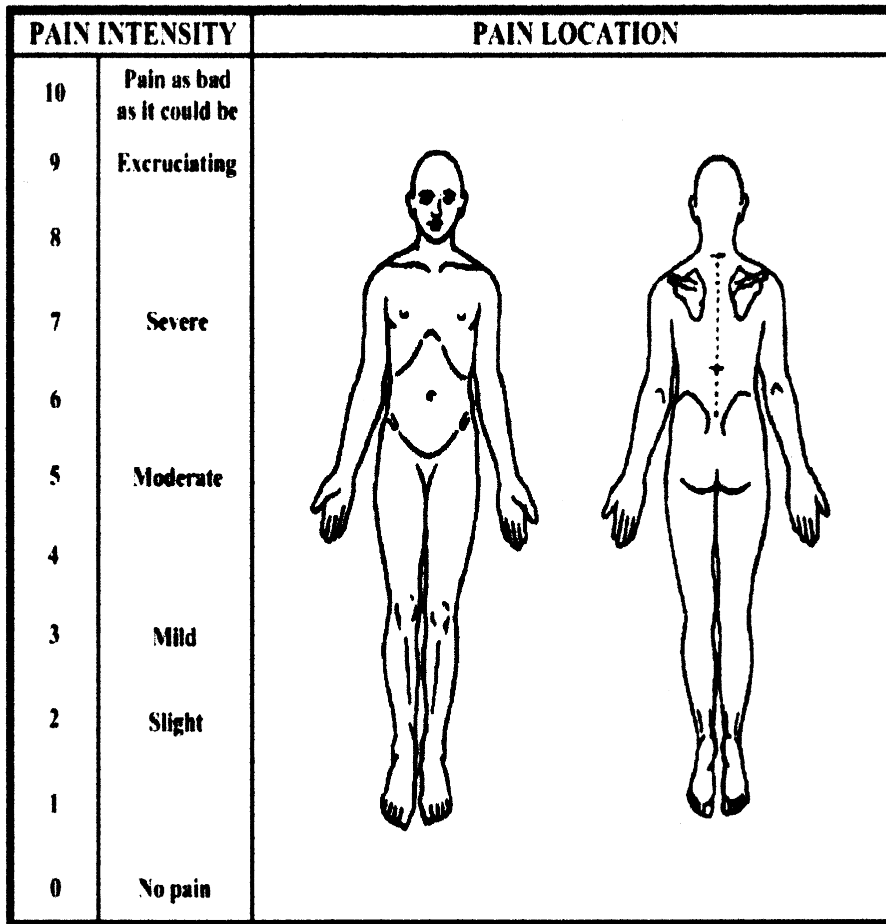
b. Daily Exercise: __________________________ Sleep: Good or Poor # of Hours:________ Dreams: Y N

c. Occupation: _______________ Employer: __________________ Hours/Week: ______ Enjoy your work? Y N

d. Nicotine and Tobacco Use Per Day: _________________________

e. Alcohol Consumption Per Week: ______________________ Caffeine Consumption Per Week: __________________

Please shade the area on the chart that corresponds with your symptoms. Then circle the number that best matches the severity of the symptoms on the scale on the left.



PAIN INTENSITY		PAIN LOCATION
10	Pain as bad as it could be	
9	Excruciating	
8		
7	Severe	
6		
5	Moderate	
4		
3	Mild	
2	Slight	
1		
0	No pain	