

Healing Point, LLC
Chinese Medicine Clinic

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Patient Health History

Please complete this questionnaire as thoroughly as possible - the information will greatly aid your practitioner. Successful health care and preventative medicine are only possible when the practitioner has a complete understanding of the patient's physical, mental and emotional states. Print all information and indicate areas of confusion with a question mark. Along with all your medical information, this form will be kept completely confidential. Thank you.

Date: ____/____/____

Name: _____
(first) (middle initial) (last)

Date of Birth: ____/____/____ Age: ____ Gender: M / F Social Security #: _____

Address: _____ City,State, Zip: _____

Home Phone: _____ Mobile: _____ Work: _____

May we contact you by phone and leave a message if necessary? Y / N If yes, at which phone #? _____

Email Address: _____ May we email you appointment reminders? Y / N

Would you like to receive periodic updates or newsletters via email? Y / N Via mail? Y / N

Do you have a: Partner? Y / N Spouse? Y / N Have you been widowed? Y / N

Do you have children? Y / N If so, what are their ages? _____

Emergency Contact's Name, Phone#, and relationship to you: _____

Educational Background: _____ Occupation: _____

Employer: _____ Hours of work per week: _____

Do you enjoy work? Y / N Why or why not? _____

How did you hear about us? _____

Can we thank someone for referring you?

When and where have you recently received health care [with any type of practitioner(s)]? _____

For what reason did you receive health care? _____

Are your current health concerns the result of: an automobile accident? Y / N a work-related injury? Y / N

Has your case been referred to an attorney? Y / N

Please identify below the health concerns that have brought you to the Healing Point Clinic (in order of importance):

Condition

Past Treatment

1. _____
How does this condition affect you? _____

2. _____
How does this condition affect you? _____

3. _____
How does this condition affect you? _____

4. _____
How does this condition affect you? _____

Please list any medications (prescribed and/or over-the-counter), vitamins, herbs, and/or supplements you are currently taking (including dosages):

History of Hospitalizations and Surgeries:

Reason

When

Reason

When

History of X-Rays/CAT Scans/MRI's/NMR's/Special Studies:

Reason

When

Reason

When

Family History (Check all that are applicable):

| | <u>Father</u> | <u>Mother</u> | <u>Sibling(s)</u> | <u>Grandparents</u> | <u>Children</u> | <u>Spouse/Partner</u> |
|-----------------------------------|---------------|---------------|-------------------|---------------------|-----------------|-----------------------|
| Age (if living) | _____ | _____ | _____ | _____ | _____ | _____ |
| Age at death | _____ | _____ | _____ | _____ | _____ | _____ |
| Cause of Death | _____ | _____ | _____ | _____ | _____ | _____ |
| Health (G)good, (P)poor | _____ | _____ | _____ | _____ | _____ | _____ |
| Cancer (specify type) | _____ | _____ | _____ | _____ | _____ | _____ |
| Diabetes | _____ | _____ | _____ | _____ | _____ | _____ |
| Heart Disease | _____ | _____ | _____ | _____ | _____ | _____ |
| High Blood Pressure | _____ | _____ | _____ | _____ | _____ | _____ |
| Stroke | _____ | _____ | _____ | _____ | _____ | _____ |
| Mental Illness | _____ | _____ | _____ | _____ | _____ | _____ |
| Asthma or Allergies | _____ | _____ | _____ | _____ | _____ | _____ |
| Kidney Disease | _____ | _____ | _____ | _____ | _____ | _____ |
| Liver Disease | _____ | _____ | _____ | _____ | _____ | _____ |
| Endocrine Disorder (thyroid, etc) | _____ | _____ | _____ | _____ | _____ | _____ |
| Gastrointestinal Disorder | _____ | _____ | _____ | _____ | _____ | _____ |
| Arthritis | _____ | _____ | _____ | _____ | _____ | _____ |
| Other | _____ | _____ | _____ | _____ | _____ | _____ |

Your Height: _____ Current Weight: _____ Past Maximum Weight: _____ When? _____

What is your most recent blood pressure reading? _____ / _____ When was this reading taken? _____

Do you have any infectious diseases? Y / N If yes, please list: _____

Childhood Illness (please circle any that you have had): Scarlet Fever Diphtheria Rheumatic Fever Mumps

Measles German Measles Chicken Pox Other(s): _____

Immunizations (please circle any that you have had): Polio Tetanus Measles/Mumps/Rubella Pertussis

Diphtheria Hib Hepatitis B Chicken Pox Other(s): _____

Please list any foods, drugs, or substances you are hypersensitive or allergic to (please include reaction): _____

For the following sections, please **circle** any symptoms or illnesses you experience **now** and underline any that you have experienced in the past:

Mental/Emotional: Mood Swings Nervousness/Anxiety Mental Tension Depression Phobias Panic Attacks
Bi-Polar Disorder Obsessive Compulsive Disorder Schizophrenia Post Traumatic Stress Disorder (PTSD)
Other(s): _____

Energy and Immunity: Fatigue Slow Wound Healing Chronic Infections Chronic Fatigue Syndrome
Frequent Colds/Flu Other(s): _____

Skin: Dry or Oily Skin Itching Rashes Hives Eczema Psoriasis Acne
Unusual or Excessive Sweating Other(s): _____

Head, Eye, Ear, Nose, and Throat: Impaired Vision Eye Pain/Strain Glaucoma Glasses/Contacts
Tearing/Dryness Impaired Hearing Ear Ringing Earaches Headaches Sinus Problems Hay Fever/Allergies
Frequent Nasal Congestion Nose Bleeds Frequent Sore Throats Teeth Grinding TMJ/Jaw Problems
Other(s): _____

Musculoskeletal: Neck/Shoulder Pain Muscle Spasms/Cramps Arm Pain Leg Pain Upper Back Pain
Mid Back Pain Low Back Pain Sensation of Heaviness in Limbs Joint Pain (if so, where?): _____
Other(s): _____

Neurological: Vertigo/Dizziness Paralysis Numbness/Tingling Muscle Weakness Loss of Balance Stroke
Poor Memory Seizures/Epilepsy Multiple Sclerosis Other(s): _____

Respiratory: Pneumonia Chronic Cough Difficulty Breathing Emphysema Pleurisy Asthma Tuberculosis
Shortness of Breath Other(s): _____

Cardiovascular: Heart Disease Chest Pain Swelling of Ankles High Blood Pressure Palpitations/Fluttering
Heart Attack Heart Murmurs Rheumatic Fever Varicose Veins Other(s): _____

Gastrointestinal: Ulcers Changes in Appetite Nausea/Vomiting Abdominal Pain Frequent Passing of Gas
Heartburn Frequent Belching Gall Bladder Disease Liver Disease Hepatitis B or C Jaundice
Hemorrhoids Bloating Diarrhea Constipation Blood or Mucus in Stool Undigested Food in Stool
Fatigue After Eating High Cholesterol Other(s): _____

Endocrine: Hypothyroid Hyperthyroid Hypoglycemia Diabetes Unusual Sensations of Hot or Cold
Cold Hands and/or Feet Night Sweats Other(s): _____

For the following sections, please **circle** any symptoms or illnesses you experience **now** and underline any that you have experienced in the past:

Urinary: Kidney Disease or Stones Painful Urination Frequent Urination Impaired Urination Blood in Urine
Frequent Urination at Night Frequent Urinary Tract Infections (UTI) Incontinence Other(s): _____

Male Reproductive: Sexual Difficulties Prostate Problems Testicular Pain/Swelling Penile Discharge
Sexually Transmitted Disease(s) Other(s): _____

Female Reproductive/Breasts: Irregular Cycles Heavy Flow Bleeding Between Cycles Painful Periods
Premenstrual Problems/Symptoms Menopausal Symptoms Vaginal Dryness Unusual Vaginal Discharge
Breast Lumps Breast Tenderness Nipple Discharge Difficulty Conceiving Endometriosis
Sexually Transmitted Disease(s) Other(s): _____

Do you have **any** reason to believe you may be pregnant? Y / N If yes, how far along are you? _____
(Please remember to inform your practitioner in the future if you have any reason to believe you might be pregnant.)

Age of First Menses: _____ Average # of Days of Menses Flow: _____ Length of Cycle (between flows): _____

Birth Control Use – Current and in Past (if applicable): _____

If applicable: # of Pregnancies: _____ # of Live Births: _____ # of Miscarriages: _____ # of Abortions: _____

Any complications during pregnancy, birth and/or postpartum? _____

Other: Anemia or Other Blood Disorders Cancer Fibromyalgia Sensation of “Foggy” or “Heavy” Head

Eating Disorder(s) Lyme’s Disease Problems with teeth and/or gums Other(s): _____

Is there anything else we should know (including other symptoms not listed above)? _____

Lifestyle:

Number of meals eaten per day: _____ Number of snacks eaten per day: _____

Types and amount of beverages per day: _____

For the following substances please indicate types and average amount of current and/or past use (if applicable):

Caffeine: _____

Nicotine: _____

Alcohol: _____

Recreational Drugs: _____

Type(s) and amount(s) of exercise each week: _____

Religious and/or spiritual practice: _____

Average hours of sleep per night _____ Do you wake rested? Y / N

Any problems falling asleep or staying asleep? Y / N If so, please describe: _____

Please rate your stress level (circle): low medium high

What are your primary sources of stress? _____

Have you experienced any major traumas (ie abuse, major accidents, homelessness, death of spouse/partner, etc)? Y / N

If so, please describe: _____

Interests and hobbies: _____

Anything else you would like us to know: _____

Thank you for taking the time to fill out this form.
It will greatly help us to assess and treat you in our clinic.