CLOVE TREE COMMUNITY ACUPUNCTURE

PATIENT HEALTH HISTORY **Date:** _____

Patient Information

Name _____
Date of Birth _____Gender ❑F ❑M
Height_____Weight_____LB
Occupation _____
Primary Physician _____
Physician phone number_____

Contact Information

Address _____
City _____ State_____ Zip_____
Phone #(Daytime) _____ Evening_____
Email: _____
Emergency Contact Name: _____
Emergency contact phone: _____
How did you hear about us? ❑website ❑flyers ❑ friends

Chief Complains

1. _____
When and how did this start? . _____
How often. _____
Severity? _____in 10
What make this better? . _____
What make this worse? . _____

2. _____
When and how did this start? . _____
How often. _____
Severity?_____in 10
What make this better? . _____
What make this worse? . _____

Have you been given diagnosis for these problem?
1._____ 2. . _____

Health History

Check conditions you have or have had in the past:

❑ Bleeding disorder ❑ Epilepsy ❑ Pacemaker
❑ Diabetes ❑ HIV/AIDS ❑ Stroke
❑ Hepatitis ❑ Heart disease ❑ Cancer
❑ Anticoagulant Use ❑ Fainting
❑ immune system compromised

Are you pregnant or try to get pregnant ❑ Yes ❑ No
Are you allergic to certain food/ medication/ herbs?
❑ No ❑ yes (please specify) _____

Life Style
❑ Vegetarian/vegan ❑ consume alcohol ❑ smoke
❑ recreational Drag use ❑ dependence on caffeine

list all medications, herbs and supplements (use extra sheet if necessary)

List serious illness, accidents or surgeries

Check any symptoms you have not or have had in the past year, and mark an X on the scales

Temperature

How warm or cold do you feel (not in degrees)

❑ Cold hands/ feet/chest ❑ Hot hands/feet
❑ Chills ❑ Hot flashes
❑ No thirst ❑Hot in afternoon/night
❑Very thirty ❑Thirst but don't want drink
❑Unusual sweats ❑night sweats

Temp of drinks/food most commonly desired:
❑ Very cold ❑ Tepid ❑very Hot

Respiratory

❑Asthma/wheezing ❑short of breath
❑cough with/ without mucus ❑pain with deep breath
❑COPD ❑sore throat
❑ loss of voice ❑sinus problem
❑bitter/metal/other taste in mouth ❑mouth sores
❑teeth grinding ❑nose bleeding
❑ enlarged glands ❑ gum problem
❑frequent colds ❑ Hayfever/allergies

Head/Ear/Eye/Skin /Hair

❑Headache/migraine ❑Dizziness/vertigo
❑Forgetful/poor memory ❑Dry/watery/itching eyes
❑eye pain/ red eye ❑ poor night vision
❑spots/floaters ❑blurred vision
❑glaucoma ❑ear ache
❑ ear ring ❑Jaw problems eyes
❑Dry skin ❑Itching skin/rash
❑Sore won't heal ❑ Bruise easily
❑Acne / psoriasis ❑ Brittle/weak nails
❑Dry hair ❑hair loss

Cardiovascular

❑ Heart palpitations ❑ Irregular heart beat
❑ Poor circulation ❑ Varicose veins
❑ Chest pain/tightness ❑ Swelling feet/ankles
❑ High blood pressure ❑ Low blood pressure
❑ History of heart attack ❑ hardening of arteries
❑ sleep apnea

Energy / Digestion

❑ Chronic fatigue
❑ Excessive hunger
❑ Poor appetite
❑ Specific cravings
❑ undigested food in stool
❑ Diarrhea
❑ Constipation
❑ Loose/soft stool
❑ Alternating diarrhea/constipation
❑ Don't feel complete after stool
❑ Tired after eating
❑ Hunger w/no desire to eat
❑ excessive hunger
❑ Mucous/blood in stool
❑ bloating or gas
❑ Abdominal Pain/ Cramps
❑ hard to pass
❑ Bloating/gas
❑ Belch/Acid reflux/heartburn
❑ Gallbladder disorder
❑ Anal fissures
❑ Rectal pain/itchiness
❑ Parasites
❑ unexplained weight changes
❑ Ulcers
❑ Other:_____
❑ Bad Breath
❑ Nausea/Vomiting
❑ Hemorrhoids
❑ Laxative use
❑ Hiccups
❑ Hernia

Bowel movement _____time(s) every ____days

Sleep

❑ Trouble falling asleep
❑ Wake easily/early
❑ Dream disturbed
❑ wake to urinate (How many times) _____
❑ Trouble staying asleep
❑ Restless sleep
❑ Difficulty waking up

Genito-urinary

❑ Painful/burning urination
❑ Frequent Urination
❑ Blood in Urine
❑ Bedwetting
❑ Kidney Stone
❑ Increased /Decreased libido
❑ Unable to Hold Urine when jumping/coughing
❑ Color of Unrine Clear/ slight yellow/ dark yellow
❑ Excessive or scant urination
❑ Urgent Urination
❑ Urine Dribbling/ Retention
❑ Genital Sores
❑ Kidney sores

For Men Only

❑ large Prostate ❑ Sexual Dysfunction ❑ Infertility

For Women Only

Color of Bleeding ❑ pink red ❑ dark red ❑ with clots
❑ Irregular Periods
❑ Heavy periods
❑ Mid-cycle spotting
❑ PMS
❑ Birth control pill
❑ Uterine fibroids
❑ Previous miscarriages
❑ Vaginal Discharge ❑ clear ❑ yellow ❑ white
❑ Painful Periods
❑ Scant periods
❑ Cramping(before/during period)
❑ Breast Lumps
❑ Vaginal Sores
❑ Endometriosis:
❑ Difficult Births

First day of last period:_____
Date of Last Pap Smear _____/ _____/ _____
Age at first Menses:_____
_____of days in cycle ___Duration of Menses

<u>Menopause</u>
Approx date/year menopause:_____
Age at last menses:_____
❑ Hot flash
❑ vaginal dryness
❑ Night sweats

Emotion

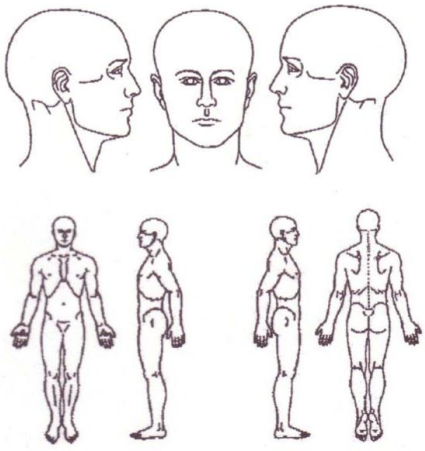
❑ Sad/Grief/depressed
❑ Impatient
❑ Easily Angered /Frustrated
❑ Stressed
❑ Manic
❑ worry
❑ Mood swings
❑ Fearful
❑ Anxiety
❑ irritability
❑ panic attack
❑ indecision
❑ easily startled
❑ Mental illness

Have you ever considered or attempted suicide? ❑ Yes ❑ No

Musculoskeletal

❑ Joint pain
❑ Muscular Weakness
❑ Muscle Spasm
❑ Injuries or Falls
❑ Muscular Atrophy
❑ Joint swelling
❑ "Heaviness" of body/limbs
❑ Other: . _____
❑ Body aches/stiffness
❑ Numbness/tingling
❑ Arthritis
❑ Recent Sprains
❑ Joint Instability
❑ Joint discoloration
❑ Limited range of motion

If your chief complain is pain, what is pain level from 0-10 ?
(0 means no pain at all) _____



Additional Comments:

The Pain is
❑ Sharp
❑ Dull
❑ Aching
❑ Burning
❑ Deep Pain
❑ Superficial Pain
❑ Numb
❑ Tingling
❑ Shooting
❑ Pain worse with cold
❑ Pain worse with hot
❑ Pain better with pressure
❑ Pain worse in Am/PM/night