Natural Bridge Acupuncture

Patient Health History

Name: _____ Date: _____/_____/_____
(first) (middle) (last)

Date of Birth: _____/_____/_____ Age: _____ Gender: _____ Marital status: S M D W

Successful health care and preventative medicine are only possible when the practitioner has a complete understanding of the patient physically, mentally, and emotionally. Please complete this questionnaire as thoroughly as possible. Thank you.

1. When and where did you last receive health care? _____

For what reason? _____

2. Has your case (current condition) been referred to an attorney? Y N

3. Please identify the health concerns that have brought you to Natural Bridge Acupuncture in order of importance below:

Condition	**Past Treatment**
a. _____	_____
How does this condition affect you? _____	
b. _____	_____
How does this condition affect you? _____	
c. _____	_____
How does this condition affect you? _____	
d. _____	_____
How does this condition affect you? _____	

4. If applicable, please list any foods, drugs, or medications you are hypersensitive or allergic to (please include reaction):

_____

_____

_____

5. Please list any medications (prescribed and over the counter), vitamins, and supplements you are currently taking:

_____

_____

_____

_____

_____

_____

6. **Health History:**

Please check all those that are applicable and give a brief explanation (type, location, date of onset, current symptom, remission, etc.):

___ Hypertension / cardiac condition _____

___Acute, severe abdominal pain _____

___Undiagnosed neurological change _____

___Unexplained weight loss or gain more than fifteen percent (15%) of body weight in less than a three (3) month period.

_____

___Suspected fracture or dislocation _____

___Suspected systemic infection _____

___Serious hemorrhagic disorder _____

___Acute respiratory distress without a previous history _____

___Pregnancy (how far along are you?) _____

___Diabetes _____

___Cancer _____

If you checked any of the above (section 6), please provide the contact information of your treating physician. I require this information so that I can consult with them. If you do not provide this information, I am unable to treat you at my clinic.

Name of Physician: _____

Address: _____

Phone: _____ Fax: _____ Email: _____

7. **Height:** _____ **Weight:** Currently: _____ Past Maximum: _____ When? _____

8. **Blood Pressure:** What is your most recent blood pressure reading? _____/_____ When was this reading taken? _____

9. **Hospitalizations and Surgeries:**

Reason	When	Reason	When
_____		_____	
_____		_____	
_____		_____	
_____		_____	

10. **X-Rays/CAT Scans/MRI's/NMR's/Special Studies:**

Reason	When	Reason	When
_____		_____	
_____		_____	
_____		_____	

11. **Emotional** (please circle any that you experience now and underline any that you have experienced in the past):

Mood Swings Nervousness Anxiety Anger Obsessive Thinking

Fear Sorrow/Greif Stress Other: _____

12. **Energy and Immunity** (please circle any that you experience now and underline any that you have experienced in the past):

Fatigue Slow Wound Healing Chronic Infections Chronic Fatigue Syndrome

13. **Head, Eye, Ear, Nose, and Throat** (please circle any that you experience now and underline any that you have experienced in the past):

Impaired Vision Eye Pain/Strain Glaucoma Glasses/Contacts Tearing/Dryness

Impaired Hearing Ear Ringing Earaches Headaches Sinus Problems

Nose Bleeds Frequent Sore Throats Teeth Grinding TMJ/Jaw Problems Hay Fever

Other: _____

14. **Respiratory** (please circle any that you experience now and underline any that you have experienced in the past):

Pneumonia Frequent Common Colds Difficulty Breathing Emphysema

Persistent Cough Pleurisy Asthma Tuberculosis

Shortness of Breath Other Respiratory Problems: _____

15. **Cardiovascular** (please circle any that you experience now and underline any that you have experienced in the past):

Heart Disease Chest Pain Swelling of Ankles High Blood Pressure

Palpitations/Fluttering Stroke Heart Murmurs Rheumatic Fever Varicose Veins

Other; _____

16. **Gastrointestinal** (please circle any that you experience now and underline any that you have experienced in the past):

Ulcers Changes in Appetite Nausea/Vomiting Epigastric Pain Passing Gas Heartburn

Belching Gall Bladder Disease Liver Disease Hepatitis B or C Hemorrhoids Abdominal Pain

Other: _____

17. **Genito-Urinary Tract** (please circle any that you experience now and underline any that you have experienced in the past):

Kidney Disease Painful Urination Frequent UTI Frequent Urination Heavy Flow

Kidney Stones Impaired Urination Blood in Urine Frequent Urination at Night

Other: _____

18. **Female Reproductive/Breasts** (please circle any that you experience now and underline any that you have experienced in the past):

Irregular Cycles Breast Lumps/Tenderness Nipple Discharge Heavy Flow

Vaginal Discharge Premenstrual Problems Clotting Bleeding Between Cycles

Menopausal Symptoms Difficulty Conceiving Painful Periods Other: _____

19. **Menstrual/Birthing History:**

Age of First Menses: _____ # of Days of Menses: _____ Length of Cycle: _____

Birth Control Type: _____ # of Pregnancies: _____ (Live Births: ____ Miscarriages: ____)

20. **Male Reproductive** (please circle any that you experience now and underline any that you have experienced in the past):

Sexual Difficulties Prostrate Problems Testicular Pain/Swelling Penile Discharge

21. **Musculoskeletal** (please circle any that you experience now and underline any that you have experienced in the past):

Neck/Shoulder Pain Muscle Spasms/Cramps Arm Pain Upper Back Pain Mid Back Pain

Low Back Pain Leg Pain Joint Pain (if so, where?): _____

22. **Neurologic** (please circle any that you experience now and underline any that you have experienced in the past):

Vertigo/Dizziness Paralysis Numbness/Tingling Loss of Balance Seizures/Epilepsy

23. **Endocrine** (please circle any that you experience now and underline any that you have experienced in the past):

Hypothyroid Hypoglycemia Hyperthyroid Diabetes Mellitus Night Sweats Feeling Hot or Cold

24. **Other** (please circle any that you experience now and underline any that you have experienced in the past):

Rashes Eczema/Hives Cold Hands/Feet

Is there anything else we should know? _____

_____

25. **Lifestyle:**

a. Do you typically eat at least three meals per day? Y N If not, how many? _____

b. How many glasses of non-caffeinated, non-carbonated beverages do you drink per day? _____

c. How often do you exercise? _____

d. How many hours per night do you sleep? _____ Do you wake rested? Y N

e. Occupation: _____ Hours/Week: _____

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

f. Nicotine/Alcohol/Caffeine Use: _____

g. Have you experienced any major traumas? Y N Explain: _____

_____

_____

h. Interests and hobbies: _____

26. **Emergency Contact**:

Name/Relation: _____ Phone: _____