Patient Health History

Name: _____ **Age:** _____ **DOB:** _____

Gender Identified: M F Intersex MtF Female FtM Male

Preferred Pronoun: He She They Other (please specify):_____

Marital Status: S M/SO D W **Live alone:** Y N

Street Address: _____

City/State/Zip: _____

Please circle the phone numbers or email where I can leave you a detailed message:

Home Phone:_____ **Mobile Phone:**_____

Work Phone: _____ **Email:**_____

□ Yes, I am interested in receiving a newsletter from Sage & Incense Acupuncture.

How did you hear about Sage & Incense Acupuncture?_____

Profession:_____ **Employer:**_____

Emergency Contact:_____

Phone Number:_____ **Relationship:**_____

Physician:_____ **Physician:**_____

Address:_____ **Address:** _____

_____ _____

Is your physician/s aware that you are seeking alternative medicine? Y / N

Have you had acupuncture or Chinese herbal medicine before? Y / N

Health Concerns (please list in order of importance)

Condition: _____ **Date of Onset:** _____

Western Diagnoses/Treatments: _____

_____ **Have these treatments helped?** Y / N

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Western Diagnoses/Treatments: _____

_____ **Have these treatments helped?** Y / N

Diet & Lifestyle

How many oz of water do you drink/day? _____**Caffeinated beverages/day:**_____ **Alcohol consumption/week:**_____**Marijuana use:** Y / N **Recreational drug use:** Y / N

Do you smoke? Y / N **How much?** _____**For how long?** _____

Did you ever smoke? Y / N **When did you quit?** _____

How often do you exercise? _____ **What kinds of exercise do to you do?** _____

Please check Never, Past, Current for each

Overall Diet	**N**	**P**	**C**	**Length of time**
Balanced omnivore				
Heavy meat eater				
Pescetarian				
Vegetarian				
Lacto-vegan (eat eggs, dairy)				
Strict vegan				
Paleo				
Other:				

Please check Usually, Sometimes, Never for each

	U	**S**	**N**		**U**	**S**	**N**
Do you eat breakfast?				Do you watch TV while eating?			
Do you eat three meals per day?				Do you eat alone?			
Do you eat at regular times?				Do you sit when you eat?			
Do you chew food thoroughly?				Are you stressed while eating?			
Do you cook your food at home?				Do you eat out more than once/week?			

Please describe your breakfast, lunch, dinner, and snacks in the past three days:

Breakfast	**Lunch**	**Dinner**	**Snacks**

Please list any foods, drugs, or medications you are sensitive or allergic to, along with reactions: ____

Patient Name/Date:

Medications/Supplements: Please list **ALL medications or supplements** (prescribed and over-the-counter) that you are currently taking or have taken in the last three months. Please attach a separate sheet if more room is needed.

Medication/Supplement	Dose	Reason/Diagnosis

Approximately how many times have you taken antibiotics? _____

Hospitalizations, Surgeries, Procedures, and Trauma (including MVAs, concussions, exploratory procedures, MRIs, X-rays, cesarean section, etc.) Please attach a separate sheet if more room is needed.

Date **Event/Procedure** **Reason/Relevant Findings**

Family History

Family Member	Current Age	Overall Health (i.e. good, poor)	Age of Death	Medical Conditions
Maternal Grandmother				
Maternal Grandfather				
Paternal Grandmother				
Paternal Grandfather				
Mother				
Father				
Siblings				

If you have any other relevent family medical history, please list it here: _____

_____

Health History

Current Height: _____ **Current Weight:**_____

Are you now, or could you be pregnant? Y / N **How far along are you?** _____

Any travel outside the U.S. in the last year? Y / N **Where?** _____

Do you have any infectious diseases? Y / N **Please identify:** _____

A history of toxic chemical exposure? Y / N **Please identify:** _____

Prenatal

Were there any unusual circumstances or difficulties with your gestation or birth (i.e. cesaerean section, forceps delivery, illness of mother, etc.)? Y / N If yes, please explain: _____

_____

Childhood

Did you have any serious childhood illnesses? Y / N If yes, please explain: _____

_____

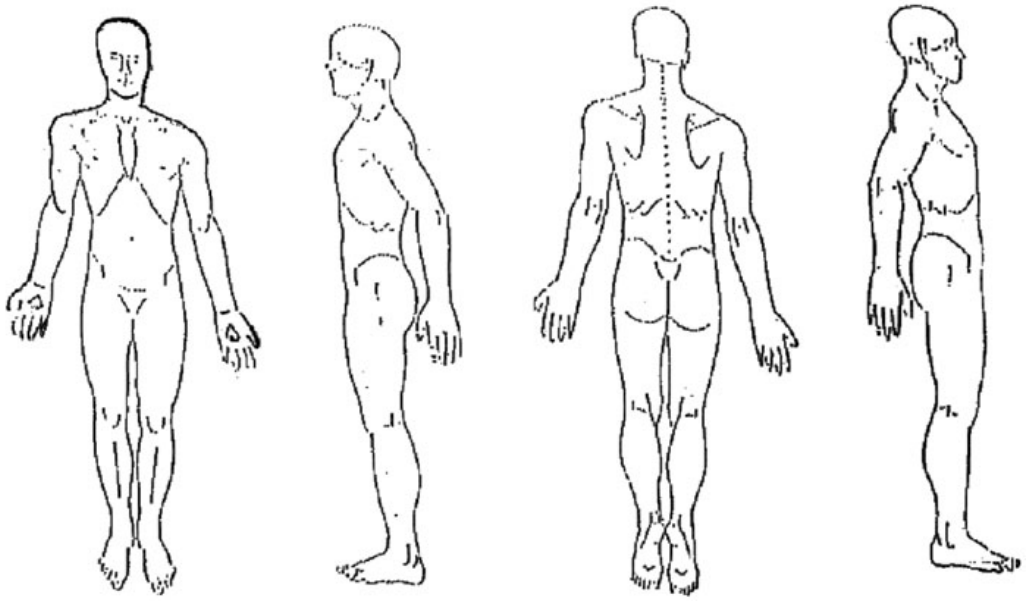
_____

Patient Name/Date:

Musculoskeleta/Neurological

Which is your dominant hand? R / L / Ambidextrous

Please mark areas of pain, discomfort, numbness, weakness, tingling or temperature change and explain, and indicate **level of pain** by the marked areas **on a scale of 1 (low) – 10 (severe).**



Please check all that apply: P (past), or C (current)

Neurological/Orthopedic

	P	C		P	C		P	C
Muscle weakness			Change in structure			Light headedness		
Muscle atrophy			Paralysis			Seizures		
Numbness/Tingling			Memory loss/confusion			Tremors		
Loss of function			Bell's Palsy			Shingles		
Referred pain			Difficult/loss of balance			Concussions		
Broken bones			Vertigo/dizziness			Other:		

Teeth, Jaw

	P	C		P	C		P	C
Teeth grinding/clenching			Crowns, bridges, or caps			Adult tooth loss		
TMD/Jaw pain			Cavities? Number:			Jaw surgery		
Trigeminal neuralgia			Root canals? Number:			Other:		

Energy/Immunity Current Energy Level: (can't move) 1 2 3 4 5 6 7 8 9 10 (vigorous)

	P	C		P	C		P	C
Persistent fatigue			Painful lymph nodes			Frequent colds/flu		
Easily fatigued with exertion			Swollen lymph nodes			Chronic infections		
Adrenal pathology			Aversion to A/C			Slow wound healing		
Persistent low grade fever			Easily chilled			Low/no libido		
Difficulty regulating body temp.			Hyper-/hypothyroidism			Other:		

Sleep/Rest **Hours of sleep/night: _____Do you keep consistent sleep hours?** Y / N

	P	C		P	C		P	C
Difficulty falling asleep			Excessive/vivid Dreams			Restless sleep		
Falling asleep from exhaustion			Difficulty waking in morning			Nightmares		
Early awakening (3-5am)			Sleep walking, talking, eating			Snoring		
Frequent waking at night			Sleep apnea			Other		

Psychoemotional

	P	C		P	C		P	C
Depression			Irritablity, quick to anger			Despair, loss of will		
Anxiety / Panic			Feelings of loneliness			Restlessness		
General Nervousness			Fearfulness			Feelings of indifference		
Mood swings			Mania			PTSD		
Ongoing grief or sadness			Easily startled			Bi-polar disorder (I / II)		
Tendency to worry			Suicidal thoughts, plans			Other:		

Respiratory

	P	C		P	C		P	C
Bronchitis			Persistent cough			Lung cancer		
Pneumonia			Difficulty breathing			Tuberculosis		
Emphysema			Shortness of breath			Lung / Throat cancer		
Pleurisy			Frequent sighing			Pulmonary Embolsim		
Asthma			Mouth breathing			Other:		

Ears, Eyes, Nose, Mouth, Throat

	P	C		P	C		P	C
Impaired vision			Poor night vision			Unusual taste in mouth		
Eye pain/strain			Ringing in the ears			Mouth sores/cold sores		
Glasses/contacts			Earaches			Easy loss of voice		
Easy/excessive tearing			Chronic ear infections			Weak/hoarse voice		
Eye dryness or lack of tears			Headaches			Dry mouth/throat		
Cataracts			Sinus contestion/pain			Chapped lips		
Floaters			Nasal allergies			Oral cancer		
Red Eyes			Nose bleeds			Other:		
Light sensitivity			Frequent colds/sore throat					

Skin/Hair/Nails

	P	C		P	C		P	C
Sweat easily, difficult to stop			Ridges in nails			Itching		
Night sweats			Brittle/peeling nails			Dry/scaly skin		
Low/no sweating			Eczema			Psoriasis		
Excess hair			Acne			Skin allergies (list):		
Unusual hair loss			Rashes			Melanoma (where):		
Dry, brittle hair			Hives			Scars (where):		

Patient Name/Date:

Cardiovascular, Circulatory

	P	C		P	C		P	C
Slow resting heart rate (<60 BPM)			High blood pressure			Stroke / TIA		
Fast resting heart rate (>80 BPM)			Low blood pressure			Aneurysm		
Feeling cold or hot frequently			Heart valve problem			Anemia		
Varicose veins / spider veins)			Palpitations			Calf cramps		
Cold / Hot hands or feet			Swollen extremities			Heart disease		
Irregular heart rate			Angina/Chest pain			Heart attack/MI		

Digestive/Gastrointestinal **Daily bowel movement?** Y / N **Number of BMs/Day:** _____

	P	C		P	C		P	C
Frequent nausea/vomiting			Frequent passing gas			Excessive appetite		
Frequent hiccoughs			Strong-smelling gas			Loss of taste		
Heartburn			Intestinal rumbling			Unusual taste		
Frequent belching			Weight change: gain / loss			Hernias		
Upper abdominal pain			Thirst: low / excessive			Bad breath		
Lower abdominal pain			Frequent food cravings			Hemorrhoids/fissures		
Intestinal polyps			Hepatitis (A, B, C, other)			Gallstones/GB Disease		
Ulcers			Low appetite			Parasites		
Constipation			Loose stool/diarrhea			Black/tarry stool		
Other:								

Urinary system

	P	C		P	C		P	C
Frequent (>6x/day)			Dark yellow urine			Cystitis		
Infrequent (<3x/day)			Strong smelling urine			Interstitial cystitis		
Light or dribbling flow			Clear urine			Bladder stones		
Uncontrolled flow/incontinence			Cloudy/bubbly urine			Bladder cancer		
Urgency			Light yellow urine			Kidney stones		
Inability to empty bladder			Urinating at night			Kidney disease		
Blood in urine			Frequent UTIs			Other:		

Reproductive (Male)

	P	C		P	C		P	C
STDs:			Prostatitis			Testicular cancer		
Low libido			Benign prostatic hyperplasia			Testicular pain		
Erectile dysfunction			Prostate cancer			Other:		

Reproductive (Female)

Breast Health	P	C		P	C		P	C
Nipple discharge			Breast trauma			Breast reduction		
Inverted nipples			Fibrocystic breasts			Breast cancer		
Breast lumps/tenderness			Breast augmentation			Breast cancer treatment		

Patient Name/Date:

Vaginal discharge	**P**	**C**		**P**	**C**		**P**	**C**
Normal amt with cycle			Yellow, strong smelling			Watery		
Excessive amount			Green, strong smeling			No discharge/vaginal dryness		
Clear, white, no smell			Thick, sticky			Frequent yeast infections		

Genital/Uterine Health	**P**	**C**		**P**	**C**		**P**	**C**
STDs:			Uterine/ovarian/endometrial cancer			Low libido		
HPV			Difficult/painful intercourse			Fibroids, polyps		
Abnormal PAP			Difficulty achieving orgasm			Cysts		
Date of last PAP:			Hysterectomy: Full / Partial			PCOS		
Endometriosis			Physical trauma to genitals			Sexual trauma or abuse		

Birth control	**P**	**C**		**P**	**C**		**P**	**C**
Condom/diaphragm			IUD: copper/hormonal			Hormonal: Pill/Patch/Ring/Shot		
Tubal ligation			Sympto-thermal (rhythm)			Length of time:		

Menses Age at first menses: _____Days of flow: _____Length of cycle: _____Age at menopause: ____

	P	**C**		**P**	**C**
Regular periods			Irregular periods		
Amenorrhea (no period)			Bleeding between periods		

Menopausal symptoms: _____

Menstrual Flow (please check what is or was typical, even if you are no longer menstruating)

	P	**C**		**P**	**C**		**P**	**C**
Bright red color			Thick/sticky consistency			Light flow		
Dull red color			Thin consistency			Scanty flow		
Pale/pink color			Watery consistency			Spotting		
Purple color			Mucous with blood			Flow starts and stops		
Black/brown color			Heavy flow			Clots: large / medium / small		
Normal consistency			Medium flow					

Premenstrual Symptoms (please check what is or was typical **Before**, **During**, or **After**)

	B	**D**	**A**		**B**	**D**	**A**		**B**	**D**	**A**
Severe/stabbing cramps				Mood swings				Food cravings			
Achy, sinking cramps				Crying, sadness				Abdominal bloating			
Moderate cramps				Irritability, anger				Clumsiness			
Slight cramps				Difficulty concentrating				Breast pain/swelling			
Back pain				Disorientation				Changes in stool			

I will notify my practitioner of any changes in my health status.

Patient Name: _____Signature: _____Date:_____

Patient Name/Date:

Pregnancies (please print one per live birth)

Pregnancies: _____# Live births: _____ # Abortions: _____# Miscarriages: _____

Trimester	**1st**	**2nd**	**3rd**	**Notes**
Age when pregnant				
Overall my pregnancy was easy				
Bleeding during pregnancy				
Morning sickness				
Digestive issues				
Body pain				
Major stressors during pregnancy				
Sleeping problems				
Preeclampsia				
Gestational diabetes				
Premature birth				

Labor/delivery		**Post Partum**	
Vaginal delivery		Depression, bonding difficulties	
Epidural		Length before menses resumed:	
Natural birth		**Breastfeeding**	
Cesarean		Difficult milk production	
Forceps		Mastitis, infection	
Labor difficult for you or baby		Difficulty latching	
Significant blood loss		How many months breastfeeding?	