PATIENT INFORMATION

Thank you for choosing Heal Oriental Medicine!

It is an honor to work with you on your personal health journey.

The answers you will provide on these forms, along with the information collected during your visits to the clinic and discussions you will share with your practitioner all add up - like individual pieces of a puzzle - to reveal a larger picture of your health and heath concerns. This holistic view allows your concerns to be addressed from a specific *branch* level, but also at a deeper *root* level.

Please take time to thoughtfully and honestly answer these questionnaires so that the picture of your health and health concerns are revealed as clearly as possible.

Name (Last, First, Middle)	Today's Date

Age	Date Of Birth	Sex	Marital Status
		❑ Male ❑ Female	❑ Single ❑ Married ❑ Separated ❑ Divorced ❑ Widowed

Phone	Email Address

Home Address		
City	State	Zip

Occupation	Business Phone
Employed By	

Spouse's Name

Emergency Contact	Relationship	Phone

Additional Information

MEDICAL HISTORY

Name (Last, First, Middle)	Today's Date

Major Complaint/Health Problem

How Long Has This Condition Persisted?

How Did This Condition Develop?

Is There Anything That Makes It Better?

Is There Anything That Makes It Worse?

Have You Ever Received Treatment For This Condition? ❑ Yes ❑ No	If Yes, When?
Where?	By Whom?
What Was The Diagnosis?	What Kinds Of Treatment?

What Were The Results Of The Treatment?

List Any Major Surgeries You Have Had

Date	Problem/Surgery

Significant Trauma (Auto Accidents, Falls, Etc)

Childhood Health Concerns (Select All That Apply)

❑ Allergies ❑ Chicken Pox ❑ Frequent Earaches ❑ Premature Birth ❑ Scarlet Fever ❑ _____

❑ Asthma ❑ Frequent Cold/Flu ❑ Frequent Sore Throat ❑ Rheumatic Fever ❑ _____ ❑ _____

Significant Illnesses (Select All That Apply)

❑ Diabetes ❑ Heart Disease ❑ Thyroid Disease ❑ _____

❑ AIDS ❑ Arthritis ❑ Autoimmune Disease ❑ Gallstones ❑ Hepatitis ❑ Venereal Disease ❑ _____

❑ Appendicitis ❑ Asthma ❑ Cancer ❑ Hypertension ❑ Kidney Stones ❑ Seizures ❑ _____

HEALTH HISTORY

Name (Last, First, Middle)	Today's Date

Please select any symptoms you currently have or have had in the past year.

Temperature
- ❑ Tend to feel hot
- ❑ Tend to feel cold
- ❑ Hot flashes
- ❑ Acute chills
- ❑ Acute fever

Energy
- ❑ Too much/nervous
- ❑ Good energy
- ❑ Okay energy/slightly low
- ❑ Low energy/fatigue

Thirst
- ❑ Thirsty & drink cold
- ❑ Thirsty & drink hot
- ❑ Thirsty, but don't drink
- ❑ Not thirsty

Perspiration
- ❑ Sweat with little exertion
- ❑ Night sweats
- ❑ Can't sweat

Head & Senses
- ❑ Naturally poor vision (without correction)
- ❑ Red/itchy eyes
- ❑ Poor hearing
- ❑ Ear ringing
- ❑ Earaches
- ❑ Frequent Headaches
- ❑ Migraines
- ❑ Sinus/nasal problems
- ❑ Poor sense of smell
- ❑ Frequent sore throats
- ❑ Poor teeth
- ❑ Mouth/tongue sores
- ❑ Lip sores
- ❑ Dry/chapped lips
- ❑ Dry mouth & throat
- ❑ Dizzy/lightheaded
- ❑ Fainting
- ❑ Heavy-headedness
- ❑ Seizures/convulsions

Sleep
- ❑ Insomnia
- ❑ Excessive sleep
- ❑ Difficulty falling to sleep
- ❑ Difficulty staying asleep
- ❑ Lots of vivid dreams
- ❑ Disturbing dreams
- ❑ Sleepwalk/sleeptalk
- ❑ Do not get enough sleep

Lungs & Heart
- ❑ Wheezing
- ❑ Cough
- ❑ Short of breath
- ❑ Frequent colds
- ❑ Seasonal allergies
- ❑ Slow heart rate
- ❑ Fast heart rate
- ❑ Irregular heart rhythm
- ❑ Chest pain
- ❑ Heart palpitations
- ❑ High blood pressure
- ❑ Low blood pressure

Musculoskeletal & Extremities
Pain, weakness, numbness in:
- ❑ Head
- ❑ Neck
- ❑ Shoulders
- ❑ Arms/elbows
- ❑ Wrists
- ❑ Hand/fingers
- ❑ Upper/mid back
- ❑ Lower back
- ❑ Hips
- ❑ Legs
- ❑ Knees
- ❑ Ankles
- ❑ Feet/toes
- ❑ Joint swelling
- ❑ Varicose Veins
- ❑ Cold hands and feet
- ❑ All over body pain
- ❑ Restricted movement
- ❑ Broken bones
- ❑ Bone deformities
- ❑ Paralysis

Appetite & Digestion
- ❑ Excessive appetite
- ❑ Poor appetite
- ❑ Excessive saliva
- ❑ Dry mouth
- ❑ Feel a "lump in throat"
- ❑ Abdominal pain
- ❑ Stomachaches
- ❑ Bloating/distention
- ❑ Gas
- ❑ Belching/hiccups
- ❑ Heartburn/reflux
- ❑ Nausea/vomiting
- ❑ Constipation
- ❑ Loose stool/diarrhea
- ❑ Alternating loose & constipation
- ❑ Cramps with BM
- ❑ Unsatisfying BM
- ❑ Hemorrhoids
- ❑ Bowel incontinence

Genitourinary
- ❑ Clear urine
- ❑ Dark urine
- ❑ Cloudy urine
- ❑ Burning urine
- ❑ Scanty urine
- ❑ Profuse urine
- ❑ Frequent urination
- ❑ Wake at night to urinate
- ❑ Incontinence
- ❑ Frequent UTIs
- ❑ Bladder prolapse

Diet & Lifestyle
- ❑ Poor diet
- ❑ Smoke cigarettes
- ❑ Drink alcohol
- ❑ Use drugs
- ❑ Too little activity/exercise
- ❑ Exercise excessively
- ❑ Eating disorder
- ❑ Job stress/concerns
- ❑ Family stress/concerns
- ❑ Other stress/concerns

Mental & Emotional
- ❑ Forgetful/poor memory
- ❑ Poor concentration
- ❑ Irritable/angry
- ❑ Sad
- ❑ Tearful/weepy
- ❑ Anxious/worried
- ❑ Can't stop thinking
- ❑ Fearful
- ❑ Manic
- ❑ Depressed
- ❑ Difficulty expressing emotions
- ❑ Frequently sigh or yawn

Skin Hair & Nails
- ❑ Thick/scaly skin/nails
- ❑ Thin skin/nails
- ❑ Dry skin/nails
- ❑ Easily bruises
- ❑ Dark undereyes
- ❑ Discolored skin
- ❑ Lumps
- ❑ Acne
- ❑ Abscesses/infections
- ❑ Nail fungus
- ❑ Prematurely gray hair
- ❑ Hair loss
- ❑ Dry/brittle hair

Family History
- ❑ Autoimmune disease
- ❑ Cancer
- ❑ Diabetes
- ❑ Heart disease
- ❑ High/low blood pressure
- ❑ Fertility concerns
- ❑ Thyroid disorder
- ❑ Mental illness

Email completed form to gina@healom.com.