Yintuition Wellness

Health History Form

Date:_____

Name:_____ Date of Birth:_____ Age:_____

Street:_____

City:_____ State:_____ Zip:_____

Phone: (H)_____ (W)_____ (M)_____

Please use my H W M number as my primary contact number

Email address:_____

☐ I would like to be added to the Yintuition Wellness email list

Emergency Contact:_____ Phone:_____

Physician:_____ Phone:_____

Main Condition(s) for which you are seeking treatment: please list in order of priority and indicate level of severity for each, using a scale of 0-10 (Best=0; Worst=10)

1)_____

2)_____

3)_____

History of Main Condition(s): When did it start? How often does it bother you? Does it interfere with work, sports, sleep, sex?

_____

_____

_____

_____

Past Medical History: list surgeries, hospitalizations, accidents, infectious diseases

_____

_____

_____

_____

Current Medications: list prescription and over-the-counter medicines, vitamins, herbs

_____

_____

Lifestyle

Do you exercise regularly? Describe._____

Do you chew, smoke or snuff tobacco? If so how much? _____

How much coffee, tea or other caffeine do you consume per week? _____

How much alcohol do you consume per week? _____

Do you use any recreational drugs? Please list. _____

Please describe your typical diet:

Breakfast	Lunch	Dinner	Snacks

Physiological Functions

Energy: Indicate overall energy level (1-10): ___/10

Fatigue: (Circle any that apply) In AM, After Work, Worse after meals, Better w/ exercise,
Worse when weather is Damp, Hot, Cold

Sleep: Hours/night _____ Trouble falling or staying asleep? _____

Thirst: How much water do you drink/day? _____ Do you feel thirsty? _____

Do you have a preference for Hot, Cold, Warm beverages? _____

Do you feel thirsty but have little desire to drink? _____

Appetite: How is your appetite? _____ Any particular taste in mouth? _____

Do you crave Sweet, Sour, Spicy, Salty, Fried foods? _____

Temperature: Do you tend to feel warmer / cooler than others? _____

Do you feel warm/feverish in afternoon? Wake up hot at night? _____

Only hands & feet feel cold? _____

Frequency of colds/flu: (number per month/year what season?)_____

Skin: Dryness Moles Large scars Spider veins Eczema Rashes

Sweat: Sweating without exertion? _____ Night sweats? _____ Lack of sweat? _____

Head: Foggy-head Dizziness Poor concentration/memory

Headaches: How often? _____ Duration? _____ Location? _____ Severity? _____

Dull ache Throbbing Sharp stabbing with Dizziness

What makes them better? _____ What triggers/makes worse? _____

Eyes: Dryness Itching Burning See Spots Poor night vision

Ears: Ringing Deafness Sensitive to noise

Nose: Sinusitis Rhinitis Post Nasal Drip Nosebleeds Recurrent Infections

Mouth: Sores in mouth/ lips Bleeding Gums Dryness in Mouth/Throat

Throat: Swollen glands Difficulty swallowing Other problems

Chest: Pain Constricted feeling Heavy feeling Palpations Burning Rib Pain

History of: Asthma Bronchitis TB Other Pulmonary Condition: _____

Difficulty taking deep breath Dry cough Productive Cough Weak/hoarse voice

Stomach: Bloating Reflux Pain Nausea Ulcer

Bowels: #per day or week_____ Tendency toward diarrhea or constipation?_____

With pain With blood With burning With mucus Hemorrhoids

Urine: # per 24 hrs _____ Waking at night to urinate? How many times?_____

Clear Pale Yellow Dark Yellow Cloudy

With burning With difficulty starting With urgency Incontinence

GYN: Age of 1st period:_____ Date of last period: _____ Age of menopause: _____

Pregnancies: #_____ Live Births: #_____ Abortions: #_____ Miscarriages: #_____

PMS: Irritability Weepiness Breast tenderness Bloating Cramps Back Pain

Length of Cycle (Day 1 to Day 1)_____ # Days of bleeding _____

Color of blood, # and size of pads/tampons, clots: _____

_____

History of yeast infections/ bacterial infections / STDs _____

Form of Birth Control: Birth Control Pill IUD Natural Family Planning None

How long have you used this form of birth control? _____

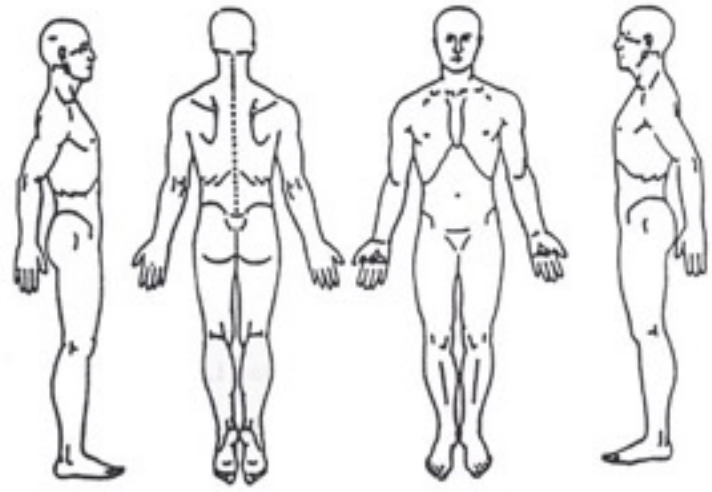
Sexual Energy: Interest (1-10) _____ Difficulty with arousal? _____

Muscular/Skeletal: Areas of pain, numbness, paralysis, tics, tremors

_____

_____

Please use the diagram below to indicate any areas of pain or tension:



Emotions: Please describe yourself emotionally_____

Are you now or have you ever been treated for depression or anxiety? _____

Stress: (1-10) _____ Home Job Partner/Spouse Money Other

Are you able to manage your stress well? or do you feel easily overwhelmed? _____

Significant losses in the past year (death of a loved one or pet, job loss, miscarriage, divorce or separation, significant move, etc).: _____

Do you feel supported by family / friends / community? _____

Fertility Patients Only

How long have you been trying to conceive?_____

Have you had fertility treatments? ☐ Yes ☐ No

If yes, when and where?_____

By whom?_____

What types?_____

Have you taken medication to help you ovulate? ☐ Yes ☐ No

When? _____

Have your fallopian tubes been evaluated medically? ☐ Yes ☐ No

What were the results?_____

Have you had any tubal operations? ☐ Yes ☐ No

Have you had any hormone laboratory tests performed? ☐ Yes ☐ No

What were the results? _____

Do you have a single partner with whom you have been trying to conceive? ☐ Yes ☐ No

How long have you been married or living together?_____

Has he had a fertility workup? ☐ Yes ☐ No

What were the results?_____

Is your partner supportive of your wish to conceive? ☐ Yes ☐ No

Have you taken oral contraceptives? ☐ Yes ☐ No

When?_____What kind?_____

Have you ever had an IUD? ☐ Yes ☐ No

When?_____

Have you had a diagnosis relating to infertility? ☐ Yes ☐ No

What was it?_____