Health History Form

First Name:	**Last Name:**	**Date:**
Address:	Email:	
Home #:	Work #:	Cell #:
Date of Birth:	Gender:	Occupation:
Emergency Contact:	Contact #:	

Chief Complaint and Duration:
(Please identify the main health problem/condition and how long you have experienced this for)

Past and Present Medical Conditions: (Please include dates)

- ☐ Allergies/Asthma
- ☐ Anemia
- ☐ Arthritis
- ☐ Cancer
- ☐ CFS/Fibromyalgia
- ☐ Depression/Mental Condition
- ☐ Diabetes
- ☐ Digestive Disorder
- ☐ Eating Disorder
- ☐ Epilepsy/Seizures
- ☐ Heart Disease/Stroke
- ☐ Hemophilia
- ☐ Hepatitis/Liver Disease
- ☐ High/Low Blood Pressure
- ☐ HIV Positive
- ☐ Kidney Disease
- ☐ Osteoporosis
- ☐ Skin Disease
- ☐ Thyroid Disease
- ☐ Other:

Please list any injuries and surgeries you have experienced with dates:

Current Medication, Supplement or Herbs: (Please indicate the condition that it treats)

Family Health History: (Please include dates)

Father:

Mother:

Other:

Lifestyle

Work hours per week: Sleep hours per night:

Special diet and food sensitivity:

Exercise type and frequency:

Caffeine/Smoke/Alcohol/Substance use and frequency:

Energy and Stress Levels: (Please circle)

Energy levels: High Average Low Extremely Low

Stress levels: Low Average High Extremely High

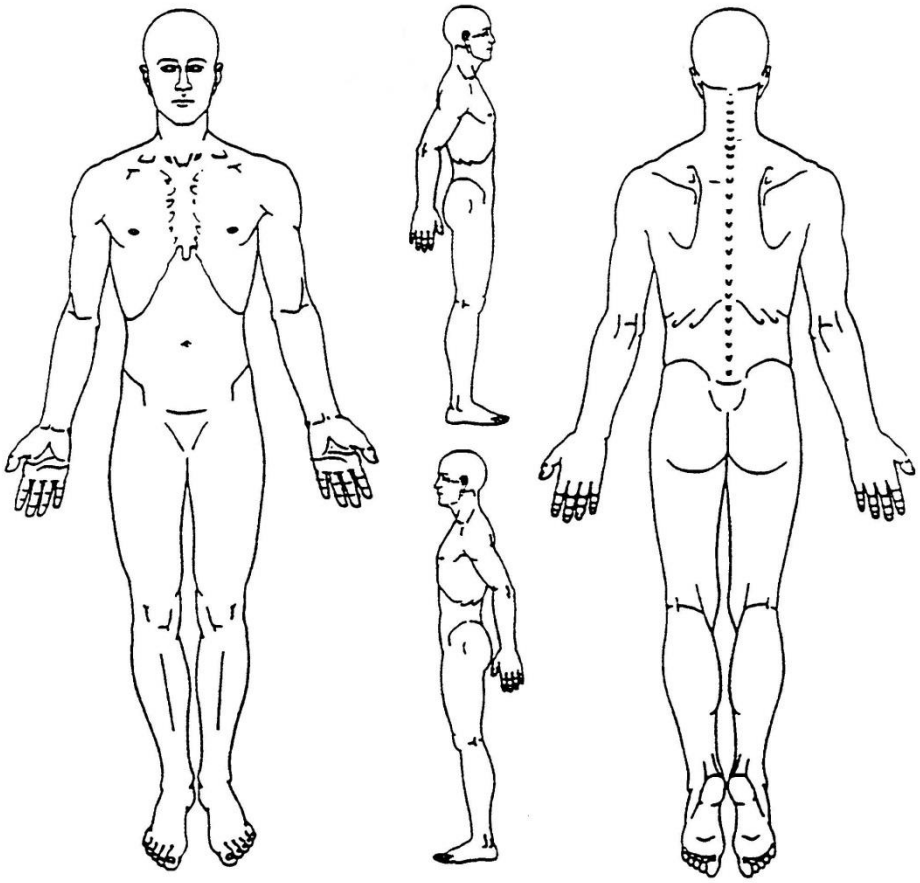
If energy or stress levels are extremely low or high, please explain:

Pain Chart

Please mark the area of pain or discomfort with the appropriate letter.

Ache/throbbing	X
Dull pain	D
Sharp stabbing	S
Burning	B
Tightness	T
Numbness	N
Pins & needles	P

Pain Scale: On a scale of 1 to 10 (10 = severe) how bad is the pain?



General Symptoms

- ☐ Fatigue
- ☐ Poor or shallow sleep
- ☐ Body heaviness
- ☐ Body feels more cold (chills)
- ☐ Body feels more warm (fever)
- ☐ Poor circulation
- ☐ Prefer cold drinks
- ☐ Prefer warm drinks
- ☐ Cold hands
- ☐ Cold feet
- ☐ Water retention or swelling
- ☐ Recent weight gain or loss
- ☐ Sweat easily

Heart Symptoms

- ☐ Insomnia
- ☐ Dream-disturbed sleep
- ☐ Anxiety
- ☐ Palpitations
- ☐ Chest pains
- ☐ Speech problem:
- ☐ Restlessness
- ☐ Hyperactivity
- ☐ Being overly talkative
- ☐ Inability to concentrate
- ☐ Poor memory
- ☐ Startled easily
- ☐ Faint easily

Liver Symptoms

- ☐ Depression
- ☐ Moody
- ☐ Irritability
- ☐ Indecisive
- ☐ Sighing
- ☐ Nervousness
- ☐ Distension pain in the chest or ribs
- ☐ Feeling of lump in the throat
- ☐ Numbness of the limbs
- ☐ Eye problem:
- ☐ Emotional triggered symptom (eg. headache, poor digestion, insomnia)
- ☐ Repressed emotions
- ☐ Easily angered
- ☐ Dizziness or vertigo
- ☐ Trembling or shaky hands
- ☐ Tics or twitching
- ☐ Muscle cramp or spasm
- ☐ Tight and stiff muscles
- ☐ Severe migraines and headaches

Spleen/Stomach Symptoms

- ☐ Improper eating habits
- ☐ Poor appetite
- ☐ Bloating and gas
- ☐ Belching and hiccup
- ☐ Abdominal distension and pain
- ☐ Loose stool
- ☐ Diarrhea
- ☐ Constipation
- ☐ Rectal problem:
- ☐ Muscle weakness
- ☐ Bleed or bruise easily
- ☐ Worry a lot
- ☐ Obsessive thoughts
- ☐ Nausea and vomiting
- ☐ Acid reflux
- ☐ Bad breath
- ☐ Mouth/gum problem:
- ☐ Cravings:

Lung Symptoms

- ☐ Cough
- ☐ Wheezing
- ☐ Shortness of breath
- ☐ Difficulty breathing
- ☐ Chest tightness
- ☐ Nose and throat problem:
- ☐ Repeated sore throat
- ☐ Swollen glands
- ☐ Sadness or grief
- ☐ Cry easily
- ☐ Foggy or clouded mind
- ☐ Skin problem:

Kidney Symptoms

- ☐ Sore/weak lower back
- ☐ Sore/weak knee joint
- ☐ Low sex drive
- ☐ Overwork or intensive workout
- ☐ Night sweat
- ☐ Teeth or hair loss
- ☐ Ear problem:
- ☐ Exhaustion or afternoon crash
- ☐ Fears
- ☐ Addictive patterns
- ☐ Abuse survivor
- ☐ Lack motivation or drive
- ☐ Forgetfulness
- ☐ Urination problem:

Gynecology

- ☐ Menopausal
- ☐ Vaginal discharge
- ☐ Breast lumps
- ☐ Currently pregnant
- # of weeks pregnant:
- # of past pregnancies:
- # of live births:
- Delivery due date:
- ☐ Irregular menstruation
- ☐ Severe menstrual cramps
- Date of last period:
- Days in cycle:
- Length of period:
- Menstrual flow, colour, clots:
- Premenstrual Symptoms:

---------- INTAKE ENDS HERE ----------

Inquiring	**Pattern**
Patient age and gender: **Chief complaint and duration:** **History of chief complaint:** (onset, nature and location of disease, accompanying symptoms, relieving and aggravating factors, medical tests and diagnosis, other treatments and treatment results) **General Information:** (10 questions, lifestyle, energy, stress, emotion, pain)	

Observation, Listening, Smelling and Palpation			
Vitality: (Spirit, face, hair, nails, skin, body shape, voice, smell)			
Tongue: (body shape, colour, movement, coating thickness, colour, moisture, location, and sublingual veins)			
Pulse: (rate, strength, quality)			
	Kidney Yang	Kidney Yin	
	Spleen	Liver	
	Lung	Heart	

TCM Disease Diagnosis:		
TCM Syndrome Differentiation	**Treatment Principles**	**Acupuncture Prescription** (Indicate additional modalities)
Primary Diagnosis: **Secondary Diagnosis:**		**# of needles in:** **# of needles out:**

Primary Practitioner (print) **Secondary Practitioner (print)** **Clinic Supervisor (print)**

Assistant Practitioner(s) (print):

Treatment Results, Treatment Plan and Recommendations: (# and frequency of Tx)