Country Well Healing Clinic

Patient Health History

Your Personal Information

Name: ___________________________________ **Date of First Treatment** ___________
Address: ____
Phone (Please indicated number to call first for appointment changes):
Work: _______________ Cell: ________________ Home: _________________
Email Address: ___________________________
Date of Birth: _____________ **Place of Birth:** ______________________
Marital Status: _______________
Please describe living situation (i.e. living with husband Dave and daughter: Nicole 8)
____
Occupation (if retired, please describe prior work): ____

How did you find Country Well Acupuncture?
Referral ____ Yellow Pages _____ Web search_____ Newspaper Ad_____ Other______
Have you tried acupuncture or qigong therapy before? (And if so, length of treatment and your experience):

Your Main Reason for Seeking Treatment:

****What is your main reason for seeking treatment?**
____
When did you first notice symptoms? Has your condition been diagnosed by a physician?
____
List medical testing done toward above diagnosis (i.e. MRI, X-Ray, psychological testing):
____
Describe medical treatment thus far (i.e. physical therapy, drugs, surgery, diet/nutrition, psychotherapy, chiropractic), noting if you are still using a treatment:
____
Describe alternative medical therapies tried for main problem noting results and if you are still using a particular therapy:
____
How has your condition/symptoms changed since its onset?
____
Does your condition adversely affect daily life?
____
Describe anything that worsens your condition (i.e. heat, cold, massage, exercise, weather changes, stress, lack of sleep, diet/foods):
____
Describe anything that improves your condition (i.e. heat, cold, massage, meditation, exercise, rest, diet/foods):

Your Doctor's Diagnoses: From Childhood to Present

****Circle** symptom within the past 2 years**, Check and date** notable conditions from your past

Addiction	AIDS	Allergies
Anemia	Anxiety	Arthritis
Asthma	Attention Deficit Disorder	ADHD
Bipolar Syndrome	Birth Trauma	Broken Bones
Bronchitis	Cancer	Chemical Sensitivity or Toxicity
Chronic Fatigue	COPD	Crohn's Disease
Depression	Diabetes	Eating Disorder
Endometriosis	Epstein Barr Virus	Fibromyalgia
Headaches	Heart/Vascular Disease	Hepatitis
Hemorrhoids	Hernia	High Blood Pressure
Hypoglycemia	Hyperactivity	Infertility
Irritable Bowel Syndrome	Kidney Disease	Lyme's Disease
Migraine Headaches	Muscle tear	Miscarriage
Neuralgia	Osteoporosis (-penia)	Panic Disorder
Parkinson's Disease	Pneumonia	Polio
Postpartum Depression	Post Traumatic Stress Disorder	Premenstrual syndrome
Prostate inflammation	Prostatitis	Repetitive stress injury
Rheumatic Fever	Seizures	Sexually transmitted disease
Skin Condition (specify)	Sinus infection	Sleep disorder (specify)
Strep Throat	Stroke	Tendon or ligament tear
Thyroid Disease	Tropical Disease	Tuberculosis
Tumor (benign)	Ulcers	***Other (specify)**

Family Medical History

*__Indicate__ family member

Allergies Asthma
____
Cancer Heart Disease
____
High Blood Pressure Mental or Emotional Condition (specify)
____
Stroke Other
____
***Are your parents still living**?
____

Surgeries, Traumas

* **Include** date/age

Surgeries____

Accidents__________________________________Shock/Emotional Trauma__________________

Occupational Stress

How many hours do you usually work/week? ________ # of days vacation/year? __________

Describe any physical or psychological stress at your work? _______________________________

Have you ever been subjected to chemical toxins at work? _________________________________

Sleep

How is your sleep? Do you wake up feeling rested?
____
What time do you go to bed? How many hours do you typically sleep?
____
**Please check if any of the following apply:

Difficulty falling asleep____ Light sleeper _____ Sleep walking ______
Heavy dreaming ____ Nightmares ____ Waking mid-sleep cycle ______
Hypersomnia ____
____

Your Diet

*Please describe a typical meal:

Breakfast

Lunch

Snack(s)

Dinner

Do you feel that you over or under eat?

How does stress affect this?

Do you crave particular food(s) or flavors?

Do you skip meals?

Do you eat breakfast regularly?

How late do you eat/have dinner?

What beverages do you typically consume/day?

How much water do you drink?

Do you eat junk food?

Please describe:

How much caffeine do you consume/day (in oz.) of coffee, teas, sodas or chocolate?

Do you smoke?

If so, how much do you smoke/day?

Do you drink alcohol?

If so, kind and quantity/day?

Exercise

What do you do to stay physically fit?____

If you are not presently exercising regularly, when was the last time you consistently exercised? ______

Do you easily feel winded? ______

Are you as flexible and coordinated as you would like to be for your age? _______

General Health

Circle if condition is within the last 2 years, **Check and date** if a past concern

Tendency to feel hot _____
Rarely thirsty? _____
Weight loss _____
Exhaustion _____
Tendency to feel cold _____
Bleeding or bruising _____
Fluctuating weight_____
Feverish over-activity _____
Always thirsty _____
Weight gain _____
Hair loss _____

Have you taken antibiotics over a long period of time? Specify:
____
Have you taken steroids over an extended period of time (i.e. steroid inhaler, predinosone, sports?

Respiratory System

*Do you feel that you easily susceptible to respiratory illness? ____________

Circle conditions within the last 2 years, **Check and date** notable past conditions:

Asthma_____
Cough_____
Nose bleeds_____
Strep Throat_____
Sinus headaches_____
Dry nose or throat _____
Difficulty exhaling _____
Allergies_____
Coughing up blood_____
Bronchitis_____
Recurrent sore throats _____
Excessive phlegm_____
Difficulty inhaling _____
Pain with exhalation _____
Sinus infections_____
COPD_____
Pneumonia_____
Sinus infections_____
Postnasal drip _____
Pain with inhalation _____
Respiratory Flu _____

Skin

Do you feel that you are easily susceptible to skin conditions? ____________________________

Circle conditions within last 2 years, **Check and date** notable past conditions:

Itching _____
Skin Ulcerations_____
Skin Pain_____
Dry skin _____
Night sweats ______
Easily chilled _____
Eczema _____
Rashes_____
Dandruff_____
Sweating _____
Dry fever at night _____
Skin infection _____
Hives_____
Moles_____
Oily skin____
Scanty sweating _____
Body odor _____
Sunburn _____

Cardiovascular

****Circle** conditions within last 2 years, **Check and date** notable past conditions:

High blood pressure _____	Low blood pressure_____	Chest pains _____
Left shoulder/arm pain _____	Irregular heartbeat _____	Dizziness _____
Fainting _____	Blood clots _____	Swelling of hands _____
Swelling of feet _____	Cold hands _____	Cold feet _____
Phlebitis _____	Palpitations _____	*Other _____________

Upper Digestion

Are you tired or energized after eating a normal meal? ____________

List any foods you feel bother your upper abdominal digestive organs: ____________________________

****Circle** condition within the last 2 years, **check and date** notable past conditions

Nausea _____	Vomiting _____	Lack of taste_____
Belching	Bad breath _____	Indigestion _____
Heartburn _____	Acid reflux _____	Gall stones _____
Sluggish digestion _____		Blood in stools (red) _____
Poor appetite/lack of hunger _____		Difficulty deciding what to eat ______
Fixed pain/cramps upper abdomen_____		Migrating pain upper abdomen/sides_____
Stomach Flus _____		

Intestines/Lower Digestion

Frequency of bowel movement? ______ Are your stools often hard, dry, soft or watery? _____

Do you take a stool softener? ______ Do you take a fiber supplement? ______

List any foods you feel bother your lower abdominal digestive organs: ____________________________

****Circle** symptoms within the last 2 years, **check and date** notable past conditions:

Black stools _____	Passing gas (mild or strong odor?) _____
Lower abdominal fixed pain/cramps _____	Lower abdominal migrating pain _____
Rectal pain_____	Hemorrhoids_____
Diarrhea_____	Constipation_____
Chronic laxative use _______	Irregularity ______
Worms _____	Bacterial Bowel infection _____
Lower digestive Flus ______	Undigested food in stools *Other _________

Head and Face

***Do you experience migraine or other headaches?** Describe age of onset, frequency, duration, location, circumstance of arising, mood, and notate if accompanied by nausea or vomiting.

____

**Check if any of the following conditions apply to you:

Bell's Palsy_____
Dizziness_____
Jaw pain_____
Jaw clicks_____
Other head and face _____
Other Stroke of Head or Face_____
Concussion_____
Jaw Clenching_____
Teeth Grinding_____

Teeth, Gums, Mouth

How often do you brush your teeth?_________ Do you use an electric toothbrush?________

*Please indicate with a check if you have experienced any of the following:

Teeth Grinding_____
Broken teeth_____
Root Canals
False Teeth_____
Sores on lips_____
Other teeth, gums, mouth (describe) _____
Cavities_____
Soft teeth_____
Tooth Implants_____
Gum disease_____
Sores on tongue or in mouth_____

Eyes

Do you wear glasses (since when? For reading or distance?)__________________________

Please check any of the following symptoms that apply, indicating which eye:

Spots in front of eyes____
Eyes strain____
Color blindness____
Macular Degeneration_____
Watery Eyes_____
Visual acuity fluctuations____
Eye pain____
Cataract(s)____
Dry eyes_____
Eye Infections_____
Blurred vision____
Poor night vision____
Glaucoma_____
Itchy eyes_____
*Other (specify)_____

Ears

****Circle** conditions within the last 2 years, **Check and date** significant past conditions

Earaches _____
Ringing in ears _____
Ear infections _____
Itchy ears
Damp ears _____
Diminished hearing ___
Other ear conditions (describe) _____

Urinary Bladder and Kidney

How often do you urinate/day? ________ Do you wake nightly to urinate (#of times)? _____

What color is your urine upon waking? __________________

***Circle** conditions within last 2 years, **Check and date** significant past conditions

Pain on urination _____
Frequent urination _____
Blood in urine _____
Cloudy urine _____
Urgency to urinate _____
Unable to hold urine _____
Decreased urine flow _____
Bladder infection(s)_____
* Other Urinary Bladder _____
Kidney stones ______
Kidney Disease ______
*Other Kidney ______

Musculoskeletal: Pain, Numbness or Weakness

***Circle** conditions within the last 2 years, **Check and date** significant past conditions.

* **Indicate if injury** Describe condition as ***pain, numbness or weakness**

*Is Condition concentrated in the **flesh, muscle body, joint or bone?**

Head/Skull ________________________
Face ________________________________
Jaw ______________________________
Neck _______________________________
Shoulders_________________________
Back _______________________________
Hip ______________________________
Leg ________________________________
wrist_____________________________
knee _______________________________
Arm ______________________________
ankle _______________________________
Hand _____________________________
foot _______________________________
Chest ____________________________
Groin _______________________________
Side of Torso ______________________
Other _______________________________

Concentration

**Check any of the following that pertain to you at present:

Poor concentration____	Poor long term memory ____	Poor short term memory ____
Block in creativity ____	Excessive thinking ____	Difficulty finishing projects ____
Difficulty planning _____	Difficulty making decisions ____	Difficulty prioritizing ____

Neuropsychological

Have you ever been in counseling with a psychotherapist or social worker?

____

Have you ever been diagnosed with a mental or emotional condition? If so, what was the diagnosis? How were you treated?

____

Have you ever seriously considered or attempted suicide? Explain:

____

**Please check if any of the below apply to you:

Tremors ____	Seizures ____	Dizziness ____
Lack of coordination ___	Areas of numbness ___	Concussion ____

*Other neurological or psychological issues (specify)

Emotional

**Check if any of the following emotional states predominate in your personality/life at present:

Anxiety _____	Bad temper _____	Depression _____
Unresolved grief _____	Lack of joy _____	Excessive Worry _____
Excessive jealousy _____	Boredom _____	Fearfulness _____
Lack of inspiration _____	Pessimism _____	Excitability _____
Lack of self esteem ____	Heartbroken _____	Critical of self and others _____
Excessive risk-taking ____	Feelings of guilt _____	Other _________________

Free Time/Relaxation

How do you spend your free time?

____

Is it easy for you to relax? What do you do to promote relaxation?

____

Male Reproductive

Please check if any of the following apply to you and describe where necessary:

Erectile dysfunction _____
Low sex drive_____
Sores on genitals _____
Penile discharge ______
Pain of genitalia _____
Sexually transmitted disease ______
Prostate condition _____
Vasectomy _____
Other genital or sexually related symptoms ______

All Women: Reproductive and Gynecologic

**Please fill in the following as pertains to you:

Age of first menses _____

Age at menopause (indicate if hysterectomy) _______

Indicate birth control methods used now and in past _______________________________

Indicated number of: Pregnancies ____ Miscarriages _____ Abortions _____

****Circle** conditions present in last 2 years, **Check and date** significant past conditions:

Fibroids ____
Sexually transmitted disease_____
Vaginal yeast infections _____
Pain with intercourse _____
Hot Flashes _____
Dry Fever ______
Other, please describe ___________
Endometriosis _____
Vaginal dryness _____
Vaginal discharge (color and smell?)_____
Lack of interest in sex _____
Night sweats ______
Uterine prolapse

For Menstruating Women Only

*Please indicate:

# of days menstruating _____

Time between cycles ______

****Circle** conditions within the last 2 years, **Check and date** significant past conditions:

Menstrual clots _____
Thin, bright red blood ______
Thick brownish blood ____
Pre-menses breast tenderness ___
Pre-menses bloating ___
Pre-menses mood changes___
Pre-menses cramping ____
Pre-menses exhaustion ___
Painful menses ___
Irregular menses ____
Heavy menstrual flow ____
Scanty menstrual flow ____
Bleeding mid-cycle ___
Exhaustion after menses _____
*Other (describe _____

Medications

List medications, herbs, vitamins and supplements **presently taking:

Condition	Medication/herb/supplements	Since when

List medications, herbs, vitamins and supplements taken **in the past:**

Condition	Medication/herb/supplements	Since when