Soul Acupuncture Clinic

Patient Health History

*Please fill in all the **gray** boxes.*

Name:		Date:		Occupation:			
Date of Birth:		Age:		Gender:		Marital Status:	
Address:							
City, State, Zip:							
Phone:					E-mail:		
Emergency Contact:		Phone:			Relationship:		

How did you hear about us: (input Y to mark)	Friend	TV	Radio	Newspaper	Health Screening	Others (please explain)

Successful health care and preventative medicine are only possible when the physician has a complete understanding of the patient physically, mentally, and emotionally. Please complete this questionnaire as thoroughly as possible.

1. Please identify the health concerns that have brought you to the clinic:
   a.
   b.
   c.

2. Are you currently receiving health care?
   If yes, where and from whom?
   If no, when and where did you last receive health care?

3. Has your case been referred to an attorney? (Work Comp, personal injury or motor vehicle injury claim, etc.)
   Please explain:

4. Are you pregnant or planning on becoming pregnant, or is there any possibility you could be pregnant?
   Please explain:

5. Do you have any chronic infectious diseases?
   Please explain:

6. Are you currently suffering from any chronic illness?
   Please explain:

7. Significant diseases, injuries, accidents, hospitalizations, surgeries, X-Rays/CAT scans/MRI's/NMR's:
   Reason & Date:
   Reason & Date:
   Reason & Date:
   Reason & Date:
   Reason & Date:

8. Please list any prescriptive medications, over-the-counter medications, vitamins, and supplements:

Name & Dose:		Name & Dose:	
Name & Dose:		Name & Dose:	
Name & Dose:		Name & Dose:	

9. Please list any foods, drugs, or medications you are hypersensitive or allergic to:

Type of reaction:		Type of reaction:	
Type of reaction:		Type of reaction:	

10. Height: Current Weight: Past Maximum Weight: When?

11. Blood Pressure: What is your most recent blood pressure reading? _____ When? _____

12. Immunizations: Check all that apply

Polio	Tetanus	Measles	Mumps	Rubella	Pertussis	Diphtheria	Hepatitis B

13. Family History:

	Mother	Father	Brothers	Sisters
Age if living				
Age at death				
Cause of death				
Health				
Cancer				
Diabetes				
Heart Disease				
Blood Pressure				
Stroke				
Mental Illness				
Other				

*The following questions apply only to **CURRENT condition.***
*Please check all that apply or input **y = yes***

14. Emotional:

Mood Swings	Depression	Anxiety	Mental Tension	Past Traumas

15. Energy/Immune:

Fatigue	Slow Wound Healing	Chronic Infections	Chronic Fatigue Syndrome	Other

16. EENT:

Ear Ringing	Headaches	Sinus Problems	Sore Throat	TMJ	Allergies

17. Respiratory:

Pneumonia	Common Colds	Difficulty Breathing	Persistent Cough	Asthma	Other

18. Cardiovascular

Heart Disease	Chest Pain	High Blood Pressure	Palpitations/Fluttering	Other

19. Gastrointestinal:

Nausea/Vomiting	Abdominal Pain	Heartburn	Gall Bladder Disease	Liver Disease

Hemorrhoids	Blood in Stool	Diarrhea	Constipation	Other

20. Genito-Urinary:

Kidney Disease	Painful Urination	Blood in Urine	Nighttime urination	Incontinence

21. Female:

Irregular Cycles	Vaginal Discharge	Bleeding Between Cycles	Premenstrual Problems	Menopausal Symptoms	Pelvic pain Infertility

22. Menstrual & Birthing History:

No. of Pregnancies:		No. of Live Births:		No. of Miscarriages/Abortion:	
Days of Menses:		Days in Cycle:		Type of Birth Control:	

23. Male:

Sexual Difficulties	Prostate Problems	Other

24. Musculoskeletal:

Neck/Shoulder	Muscle Cramps	Arm	Leg	Back	Joint

25. Neurological:	Vertigo/Dizziness	Paralysis	Numbness	Loss of Balance	Seizures	Stroke

26. Metabolic:	Hypothyroidism	Hypoglycemia	Hyperthyroidism	Diabetes	Night Sweats	Other

27. Other:	Anemia	Cancer	Rashes	Eczema/Hives	Cold Hands/Feet	Other

28. Lifestyle

a. Please indicate typical food and beverage intake:

Breakfast	Lunch	Dinner	Snacks

b. Daily Exercise: _____ How many hours: _____

Sleep: Good or Poor _____ No. of Hours: _____ Dreams: _____

c. Occupation: _____ Employer: _____ Hrs/Wk: _____ Enjoy work? _____

d. Nicotine and Tobacco Use per Day: _____

Alcohol Consumption per Week: _____

Caffeine Consumption per Week: _____

**** For Official Use Only ****

Wt./Height _____ Primary language spoken if not English: _____

BMI: _____ BP/Pulse: _____ Temp: _____

Pacemaker: _____ Coumadin: _____ Pregnancy: _____