



Allyson O'Connell Nevard, L. Ac.
Chinese, Japanese and Dr. Tan style acupuncture
Chinese herbal medicine

Acupuncture and Chinese Herbal Medicine Health History Form

Please take the time to fill this form out as thoroughly as possible. An accurate diagnosis is dependent on the information provided here. *All of your answers will be held absolutely confidential.* If there is anything additional you wish to bring to my attention, please note it in the "comments" section.
Thank you.

Name (first and last) _____ Date _____

Address _____

Home phone _____ Work _____ Cell _____

E-mail _____

Birth date _____ Height _____ Weight _____

Occupation _____

Emergency Contact Name _____ phone _____

Have you been treated with acupuncture or Chinese herbal medicine before? _____

Reason for visit

What is the main problem you would like me to help you with?

How long ago did this problem begin?

To what extent does this problem interfere with you daily activities such as work, exercise, sleep, sex?

Have you been given a diagnosis for this problem? If so, what?

Are you on any medication for this problem? If so, what?

What other kinds of treatment have you tried?



Past Medical History (Please include date)

Significant Illnesses (please circle all applicable)

Cancer	Diabetes	Hepatitis	High Blood Pressure
Heart Disease	Seizures	Stroke	Thyroid Disease

Other Diagnosis _____

Do you have a pacemaker? _____

Do you have any allergies? _____

Surgeries or Significant Traumas _____

Family Medical History (Please circle all applicable)

Asthma	Cancer	Diabetes	High Blood Pressure	Heart Disease	Seizures
Stroke					

Other: _____

Daily Habits

Medicines taken within the past 2 months _____

Do you have a regular exercise program? If so, what? _____

Do you smoke? If so, how much? _____

How much caffeinated coffee, tea or soda do you drink per week? _____

How much water do you drink daily? _____

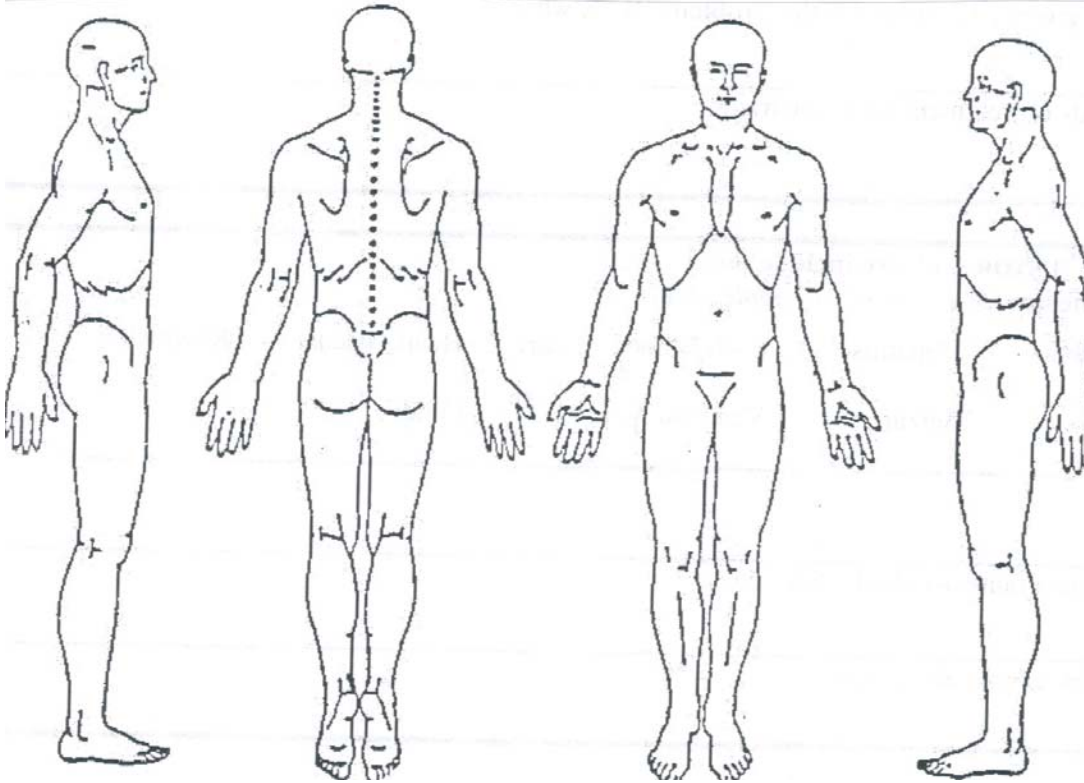
How much alcohol do you drink per day? _____

Please describe your average daily diet below

Name _____ Date _____



Please indicate any painful or distressed areas on the figures below.



<u>morning</u>	<u>afternoon</u>	<u>evening</u>

Please check if you have had (in the last three months):

General		
<input type="checkbox"/> Fevers	<input type="checkbox"/> Poor sleeping	<input type="checkbox"/> Fatigue
<input type="checkbox"/> Sweat easily	<input type="checkbox"/> Chills	<input type="checkbox"/> Night sweats
<input type="checkbox"/> Bleed or bruise easily	<input type="checkbox"/> Weight loss	<input type="checkbox"/> Cravings
<input type="checkbox"/> Peculiar tastes or smells	<input type="checkbox"/> Strong thirst (hot or cold drinks)	<input type="checkbox"/> Change in appetite
<input type="checkbox"/> Sudden energy drop (what time of day?)		<input type="checkbox"/> Weight gain

Skin & Hair		
<input type="checkbox"/> Rashes	<input type="checkbox"/> Ulcerations	<input type="checkbox"/> Hives
<input type="checkbox"/> Itching	<input type="checkbox"/> Eczema	<input type="checkbox"/> Pimples
<input type="checkbox"/> Dandruff	<input type="checkbox"/> Loss of hair	<input type="checkbox"/> Recent moles
<input type="checkbox"/> Change in hair or skin texture		
<input type="checkbox"/> Any other hair or skin problems?		

Head, eyes, ears, nose, and throat		
<input type="checkbox"/> Dizziness	<input type="checkbox"/> Concussions	<input type="checkbox"/> Migraines
<input type="checkbox"/> Glasses	<input type="checkbox"/> Eye strain	<input type="checkbox"/> Eye pain
<input type="checkbox"/> Poor vision	<input type="checkbox"/> Night blindness	<input type="checkbox"/> Color blindness
<input type="checkbox"/> Cataracts	<input type="checkbox"/> Blurry vision	<input type="checkbox"/> Earaches
<input type="checkbox"/> Ringing in ears	<input type="checkbox"/> Poor hearing	<input type="checkbox"/> Spots in front of eyes
<input type="checkbox"/> Sinus problems	<input type="checkbox"/> Nose bleeds	<input type="checkbox"/> Recurrent sore throats
<input type="checkbox"/> Grinding teeth	<input type="checkbox"/> Facial pain	<input type="checkbox"/> Sores on lips or tongue
<input type="checkbox"/> Teeth problems	<input type="checkbox"/> Jaw clicks	<input type="checkbox"/> Headaches (where, when?)
<input type="checkbox"/> Any other head or neck problems?		

Cardiovascular		
<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Low blood pressure	<input type="checkbox"/> Chest pain
<input type="checkbox"/> Irregular heartbeat	<input type="checkbox"/> Difficulty in breathing	<input type="checkbox"/> Fainting
<input type="checkbox"/> Cold hands or feet	<input type="checkbox"/> Swelling of hands	<input type="checkbox"/> Swelling of feet
<input type="checkbox"/> Blood clots	<input type="checkbox"/> Phlebitis	
<input type="checkbox"/> Any other heart or blood vessel problems?		

Respiratory		
<input type="checkbox"/> Cough	<input type="checkbox"/> Coughing blood	<input type="checkbox"/> Asthma
<input type="checkbox"/> Bronchitis	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Pain with a deep breath
<input type="checkbox"/> Difficulty in breathing when lying down		<input type="checkbox"/> Production of phlegm What color?
<input type="checkbox"/> Any other lung/breathing problems?		

Gastrointestinal		
<input type="checkbox"/> Nausea	<input type="checkbox"/> Vomiting	<input type="checkbox"/> Diarrhea
<input type="checkbox"/> Constipation	<input type="checkbox"/> Gas	<input type="checkbox"/> Belching
<input type="checkbox"/> Black stools	<input type="checkbox"/> Blood in stools	<input type="checkbox"/> Indigestion
<input type="checkbox"/> Bad breath	<input type="checkbox"/> Rectal pain	<input type="checkbox"/> Hemorrhoids
<input type="checkbox"/> Bleeding gums	<input type="checkbox"/> Abdominal pain or cramps	<input type="checkbox"/> Chronic laxative use
<input type="checkbox"/> Any other problems with your stomach or intestines?		

Name _____ Date _____

Genito-Urinary

- | | | |
|--|---|--|
| <input type="checkbox"/> Pain upon urination | <input type="checkbox"/> Frequent urination | <input type="checkbox"/> Blood in urine |
| <input type="checkbox"/> Urgency to urinate | <input type="checkbox"/> Unable to hold urine | <input type="checkbox"/> Kidney stones |
| <input type="checkbox"/> Decrease in flow | <input type="checkbox"/> Impotency | <input type="checkbox"/> Sores on genitals |
| <input type="checkbox"/> Do you wake up to urinate?
How often? | <input type="checkbox"/> Any particular color to your
urine: | |
| <input type="checkbox"/> Any other problems with your genital or urinary system? | | |

Reproductive and gynecologic

- Are you pregnant? Yes No
- Is it possible that you are pregnant? Yes No
- | | | |
|---|---|---|
| <input type="checkbox"/> Pregnancies
#: | <input type="checkbox"/> Live births
#: | <input type="checkbox"/> Miscarriages
#: |
| <input type="checkbox"/> Abortions
#: | <input type="checkbox"/> Premature births
#: | <input type="checkbox"/> Age of first menses |
| <input type="checkbox"/> Period between menses | <input type="checkbox"/> Duration of menses | <input type="checkbox"/> Unusual character (heavy, light) |
| <input type="checkbox"/> Irregular periods | <input type="checkbox"/> Painful periods | <input type="checkbox"/> Clots |
| <input type="checkbox"/> Last PAP | <input type="checkbox"/> Vaginal discharge | <input type="checkbox"/> Vaginal sores |
| <input type="checkbox"/> Breast lumps | <input type="checkbox"/> Menopause
Age: | |
| <input type="checkbox"/> Changes in body/psyche prior to menstruation | | |
| <input type="checkbox"/> Do you practice birth control? What type and for how long? | | |

Musculoskeletal

- | | | |
|--|--|---|
| <input type="checkbox"/> Neck pain | <input type="checkbox"/> Muscle pain | <input type="checkbox"/> Knee pain |
| <input type="checkbox"/> Back pain | <input type="checkbox"/> Muscle weakness | <input type="checkbox"/> Foot/ankle pains |
| <input type="checkbox"/> Hand/wrist pains | <input type="checkbox"/> Shoulder pain | <input type="checkbox"/> Hip pain |
| <input type="checkbox"/> Any other joint or bone problems? | | |

Neuropsychological

- | | | |
|--|---|--|
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Loss of Balance |
| <input type="checkbox"/> Areas of numbness | <input type="checkbox"/> Lack of coordination | <input type="checkbox"/> Poor memory |
| <input type="checkbox"/> Concussion | <input type="checkbox"/> Depression | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> Bad temper | <input type="checkbox"/> Easily susceptible to stress | |
- Have you ever been treated for emotional problems?
- Have you ever considered or attempted suicide?
- Any other neurological or psychological problems?

Comments

Briefly tell me of any other problems you would like to discuss.
