Marshall Acupuncture & Herb Clinic

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www.marshallacupuncture.com

Patient Health History

Please complete this questionnaire as thoroughly as possible so we can create the best treatment plan for you. All your answers will be held absolutely confidential. If you have any questions about this form, please ask.

Name: _____ Date: _____

Date of Birth: _____/_____/_____ Age: _____ Gender: M F Weight: _____ Height: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone #: _____ Email: _____

Marital Status: single married divorced widowed partnered

Emergency Contact: _____ Phone: _____

Primary Care Physician: _____ Phone: _____

How did you hear about Marshall Acupuncture & Herb Clinic? _____

_____

Have you ever used Chinese medicine for your health care? _____

If so, for what reason? _____

_____

MAIN CONCERNS

Please indicate your top 3 health concerns and how long you have been experiencing them:

1. _____
2. _____
3. _____

Western Medical Diagnosis, if any: _____

What goals would you like to achieve with our sessions? _____

_____

GENERAL HISTORY

How many hours of sleep do you average each night? _____ Do you experience: ☐ Difficulty falling asleep ☐ Difficulty staying asleep ☐ Wake up groggy, unrested ☐ Nightmares ☐ Vivid dreams ☐ No dreams

How many bowel movements do you average per day or week? _____

Are your bowel movements: ☐ Well-formed ☐ Loose/broken ☐ Small pebbles ☐ Skinny ☐ Difficult to pass

Please list any medications, vitamins or supplements you are taking: _____

_____

_____

List any serious illnesses, accidents or surgeries and the date they occurred: _____

_____

_____

Do you have any infectious diseases: Y / N If yes, please identify: _____

EMPLOYMENT

Occupation:_____ Company Name: _____

Most of the day is spent: ☐ Sitting ☐ Standing ☐ Very active

Do you enjoy your work? Y / N What activities/hobbies do you most enjoy doing? _____

_____

How would you rate your energy level on a scale from 1-10, with 10 being the highest: _____

How would you rate your stress level on a scale from 1-10, with 10 being the highest: _____

FAMILY MEDICAL HISTORY

Please check any condition that applies to your immediate family. Then put a F (father), M (mother), S (sister), B (brother), GM (grandmother), or GF (grandfather) next to the condition.

☐ Diabetes _____ ☐ Seizures _____ ☐ Heart Disease _____ ☐ Stroke _____

☐ Cancer _____ ☐ Allergies _____ ☐ Mental Illness _____ ☐ Asthma_____

☐ Kidney Disease_____ ☐ Lung Disease _____ ☐ Substance Abuse_____

☐ Other:_____

PERSONAL HEALTH HISTORY

Please check any that you have or have had in the past year.

MUSCLE/JOINT/BONES

☐ Tremors	☐ Arthritis	☐ Swollen Joints	☐ Cramps
Pain, weakness, numbness in: ☐ Back		☐ Feet	☐ Hips
☐ Neck/shoulders	☐ Arms or legs	☐ Hands	☐ Other: _____

EYES, EARS, NOSE, THROAT, RESPIRATORY

☐ Asthma/wheezing	☐ Enlarged glands	☐ Hoarseness	☐ Persistent cough
☐ Blurred or failed vision	☐ Eye dryness or irritation	☐ Gum trouble	☐ Ringing in ears
☐ Shortness of breath	☐ Frequent colds	☐ Nose bleeds	☐ Sinus problems
☐ Earaches	☐ Hay fever/allergies	☐ Hearing loss	☐ Headaches/migraines

SKIN & HAIR

☐ Itching/rash	☐ Dry skin	☐ Sweats easily	☐ Bruise easily
☐ Boils	☐ Sensitive skin	☐ Eczema	☐ Hair loss
☐ Slow wound healing	☐ Psoriasis	☐ Brittle hair or nails	☐ Acne

GENITO/URINARY

☐ Blood/pus in urine	☐ Inability to control urine	☐ Kidney disease	☐ Painful urination
☐ Frequent urination	☐ Kidney stones	☐ Lowered libido	☐ Urinary dribbling

CARDIOVASCULAR

- ☐ Chest pain
- ☐ Hardening of arteries
- ☐ High/low blood pressure
- ☐ Poor circulation
- ☐ Previous heart attack
- ☐ Swelling of ankles
- ☐ Irregular heartbeats
- ☐ Blood clots
- ☐ Palpitations/fluttering
- ☐ Heart murmurs
- ☐ Fainting
- ☐ Stroke

GASTROINTESTINAL

- ☐ Belching, gas, bloating
- ☐ Food allergies
- ☐ Constipation
- ☐ Diarrhea
- ☐ Difficulty swallowing
- ☐ Abdominal pain/cramps
- ☐ Poor appetite
- ☐ Excessive appetite
- ☐ Gallbladder trouble
- ☐ Hemorrhoids
- ☐ Acid reflux/GERD
- ☐ Nausea
- ☐ Vomiting
- ☐ Indigestion
- ☐ Liver disease
- ☐ Bad breath

EMOTIONAL/MENTAL

- ☐ PTSD/Trauma
- ☐ Depression
- ☐ Frequent crying
- ☐ Obsessive/compulsive
- ☐ Anxiety/Stress
- ☐ Mood swings
- ☐ Loneliness
- ☐ Eating disorder
- ☐ Addiction
- ☐ Excessive fear/worry
- ☐ Lack of motivation
- ☐ Pessimistic thinking
- ☐ Panic attacks
- ☐ Angry outbursts
- ☐ Suicidal thoughts

OTHER

- ☐ Anemia
- ☐ Bleeding disorder
- ☐ Colon polyps
- ☐ Dizziness
- ☐ Breast lump
- ☐ ADD/ADHD
- ☐ Fatigue/tiredness
- ☐ Cancer
- ☐ Night sweats
- ☐ Diabetes

FOR MEN ONLY

- ☐ Erection difficulties
- ☐ Prostate trouble
- ☐ Testicular pain/swelling
- ☐ STDs _____
- ☐ Penile discharge
- ☐ Interrupted urination
- ☐ Sexual difficulties

FOR WOMEN ONLY

- ☐ Bleeding between cycle
- ☐ Clots in menses
- ☐ Scanty menstrual flow
- ☐ STDs _____
- ☐ Heavy flow
- ☐ Extreme menstrual pain
- ☐ Breast tenderness
- ☐ Painful intercourse
- ☐ Irregular cycle
- ☐ Menopausal symptoms
- ☐ Ovarian cysts
- ☐ Excessive/odorous vaginal discharge
- ☐ PMS
- ☐ Previous miscarriage
- ☐ Fibroids

Could you be pregnant? Y / N

Is there anything else that you would like us to know before your treatment? _____

_____

_____

SIGNATURE

The information on this form is correct to the best of my knowledge.

Signature: _____ Date: _____