Columbia River Acupuncture, LLC

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Patient Health History

Thank you for taking the time to fill out this form. Successful health care and preventative medicine are possible when the practitioner has a complete understanding of the patient, which includes his/her physical, mental, emotional and spiritual aspects. Please complete this questionnaire as thoroughly as possible and print all information. Mark any question that you don't understand. Please bring this completed form with you on your first visit. Thanks.

Name:_____ **Date of Birth:**_____ **Today's Date:**_____

What are your primary concerns today?_____

_____

Are you currently receiving healthcare? Yes_____ **No** _____

If yes, where and from whom?_____

List your most important health concerns, in order of importance:

1)_____

2)_____

3)_____

4)_____

General: **Weight** _____ **Weight 1 yr. ago**_____ **Maximum Weight** _____ **When?**_____
Height _____ **When during the day is your energy best?**_____ **Worst?**_____

Personal Medical History

Please check applicable illnesses that you've had:

Chicken Pox_____ **Measles** _____ **Mumps**_____ **Diphtheria**_____

German Measles _____ **Scarlet Fever** _____ **Rheumatic Fever**_____

Hospitalizations – Surgeries:_____ **Please explain, including dates:** _____

_____

_____

X-rays, CT scan, ultrasound, EKG, EEG, mammogram, other studies and results: _____

_____

Do you have any contagious diseases at this time? Yes_____ **No**____ **If yes, please list.**_____

Please check the following immunizations that you've had:

Polio _____ Pertussis_____ Tetanus_____ Diphtheria _____ Small Pox _____

Hepatitis A _____ Hepatitis B _____ Chicken Pox _____ Influenza (date)_____

Other:_____ Any reactions?_____

Allergies - Are you allergic or hypersensitive to:

Any drugs?_____

Any foods?_____

Any plants or animals?_____

Other:_____

What is your typical reaction?_____

Family History:

	Father	Mother	Brothers	Sisters	Spouse	Child
Age (if living)						
Health (G=Good, P=Poor)						
Age at death (if deceased)						
Cause of death						
Check those applicable:						
Cancer						
Diabetes						
Heart Disease						
High Blood Pressure						
Stroke						
Epilepsy						
Mental Illness						
Asthma/Hayfever/Hives						
Anemia						
Kidney Disease						
Glaucoma						
Tuberculosis						

Current Medications:

Please check the following medications that you take as needed (PRN) or use on a regular basis (DAILY):

Laxatives_____ Cortisone _____ Tranquilizers _____ Pain relievers _____

Antacids_____ Antibiotics _____ Sleeping Pills_____ Appetite Suppressants_____

Thyroid Medication _____ Hormone Replacement (Estrogen) _____ Other_____

List prescription medications, over-the-counter medications, vitamins, herbal supplements that you take.

1)_____ 4)_____

2)_____ 5)_____

3)_____ 6)_____

Current Nutritional Status: Please list your typical food intake:

Breakfast:_____

Lunch:_____

Dinner:_____

Snacks:_____

Do you have cravings for any specific foods? Which ones?_____

Personal-Medical Review of Systems

Please circle: Y = a condition you now have N = never had P = condition you have had in the past

Head -	Headaches?	Y	P	N	Head Injury?	Y	P	N
	Migraines?	Y	P	N	Jaw - TMJ problems?	Y	P	N
Eyes -	Spots in eyes?	Y	P	N	Cataracts?	Y	P	N
	Impaired vision?	Y	P	N	Glasses or contacts?	Y	P	N
	Color blindness?	Y	P	N	Tearing or dryness?	Y	P	N
	Double vision?	Y	P	N	Glaucoma?	Y	P	N
Ears -	Impaired hearing?	Y	P	N	Ringing sounds?	Y	P	N
	Earaches?	Y	P	N				
Skin -	Rashes?	Y	P	N	Eczema, Hives?	Y	P	N
	Acne, Boils?	Y	P	N	Itching?	Y	P	N
	Color changes?	Y	P	N	Perpetual hair loss?	Y	P	N
	Lumps?	Y	P	N	Night sweats?	Y	P	N
	Unusual moles?	Y	P	N	Skin cancer?	Y	P	N

Neurologic - Seizures?	Y	P	N	**Paralysis?**	Y	P	N
Muscle weakness?	Y	P	N	**Numbness or tingling?**	Y	P	N
Loss of memory?	Y	P	N	**Easily stressed?**	Y	P	N
Vertigo or dizziness?	Y	P	N	**Loss of balance?**	Y	P	N
Endocrine							
Hypothyroid?	Y	P	N	**Heat or cold intolerance?**	Y	P	N
Hyperthyroid?	Y	P	N	**Fatigue?**	Y	P	N
Excessive thirst?	Y	P	N	**Excessive hunger?**	Y	P	N
Diabetes?	Y	P	N	**Hypoglycemia?**	Y	P	N
Emotional							
Mood swings?	Y	P	N	**Depression?**	Y	P	N
Anxiety or nervousness?	Y	P	N	**Tension?**	Y	P	N
Treated for emotional problems?	Y	P	N	**Considered / attempted suicide?**	Y	P	N
Seasonal depression?	Y	P	N				
Immune System							
Fatigued?	Y	P	N	**Chronic infections?**	Y	P	N
Chronically swollen glands?	Y	P	N	**Slow wound healing?**	Y	P	N
Nasal and Sinuses							
Frequent colds?	Y	P	N	**Nose bleeds?**	Y	P	N
Nasal congestion?	Y	P	N	**Hayfever?**	Y	P	N
Sinus problems?	Y	P	N	**Loss of smell?**	Y	P	N
Mouth and Throat							
Frequent sore throat?	Y	P	N	**Copious saliva?**	Y	P	N
Hoarseness?	Y	P	N	**Sores on tongue or lips?**	Y	P	N
Gum problems?	Y	P	N	**Teeth grinding?**	Y	P	N
Dental cavities?	Y	P	N	**Jaw clicks?**	Y	P	N
Sour breath?	Y	P	N	**Dry throat?**	Y	P	N
Respiratory							
Cough?	Y	P	N	**Sputum?**	Y	P	N
Spitting up blood?	Y	P	N	**Wheezing?**	Y	P	N
Asthma?	Y	P	N	**Bronchitis?**	Y	P	N
Pneumonia?	Y	P	N	**Pleurisy?**	Y	P	N
Emphysema?	Y	P	N	**Shortness of breath?**	Y	P	N
Pain on breathing?	Y	P	N	**Tuberculosis?**	Y	P	N
Neck							
Swollen glands?	Y	P	N	**Goiter?**	Y	P	N
Pain or stiffness?	Y	P	N	**Lumps?**	Y	P	N

Cardiovascular

Heart disease?	Y	P	N	Angina?	Y	P	N
High blood pressure?	Y	P	N	Low blood pressure?	Y	P	N
Blood clots?	Y	P	N	Heart murmur?	Y	P	N
Palpitations / fluttering?	Y	P	N	Fainting?	Y	P	N
Rheumatic fever?	Y	P	N	Swelling in ankles?	Y	P	N

Blood /Peripheral Vascular

Easy bleeding or bruising?	Y	P	N	Anemia?	Y	P	N
Deep leg pain?	Y	P	N	Cold hands / feet?	Y	P	N
Varicose veins?	Y	P	N	Thrombophlebitis?	Y	P	N

Gastrointestinal

Trouble swallowing?	Y	P	N	Heartburn?	Y	P	N
Change in thirst?	Y	P	N	Change in appetite?	Y	P	N
Nausea?	Y	P	N	Vomiting?	Y	P	N
Vomiting blood?	Y	P	N	Blood in stools?	Y	P	N
Bowel movements - How often _____				Pain or cramps?	Y	P	N
Is this a change for you? _____				Constipation?	Y	P	N
Diarrhea?	Y	P	N	Black stools?	Y	P	N
Belching or passing gas?	Y	P	N	Gallbladder dis. /gallstones?	Y	P	N
Jaundice (yellow skin)?	Y	P	N	Ulcer?	Y	P	N
Liver disease?	Y	P	N	Hemorrhoids?	Y	P	N

Urinary

Pain on urination?	Y	P	N	Increased freq of urination?	Y	P	N
Frequency at night?	Y	P	N	Inability to hold urine?	Y	P	N
Frequent infections - bladder?	Y	P	N	Kidney infections?	Y	P	N
Kidney stones?	Y	P	N	Kidney disorders?	Y	P	N

Musculoskeletal

Broken bones?	Y	P	N	Weakness in muscles?	Y	P	N
Muscle spasms or cramps?	Y	P	N	Sciatica?	Y	P	N
Back pain?	Y	P	N	Disc herniation in neck/back?	Y	P	N
Areas of pain? _____				Knee problems?	Y	P	N

Male Reproduction

Hernia?	Y	P	N	Testicular masses?	Y	P	N
Testicular pain?	Y	P	N	Prostate difficulty?	Y	P	N
Venereal disease?	Y	P	N	Discharge or external sores?	Y	P	N
Chlamydia?	Y	P	N	Condyloma?	Y	P	N
Genital herpes?	Y	P	N				
Are you sexually active?	Y	N		Any difficulties?	Y	P	N
Birth control? Type?	_____						

Female Reproduction

Age of first menses?	_____						
Duration of menses?	_____ days			Are cycles regular?	Y	N	
Painful menses?	Y	P	N	Clotting?	Y	P	N
Heavy or excessive flow?	Y	P	N	Discharge?	Y	P	N
PMS symptoms?	Y	P	N	Birth control?_____ Type?	_____		
If yes, symptoms:	_____			Number of pregnancies?	_____		
_____	_____			Number of live births?	_____		
Endometriosis?	Y	P	N	Number of miscarriages?	_____		
Ovarian cysts?	Y	P	N	Number of abortions?	_____		
Difficulty in conceiving?	Y	P	N	Cervical dysplasia?	Y	P	N
Abnormal PAP test?	Y	P	N	Venereal disease?	Y	P	N
				Chlamydia?	Y	P	N
Genital herpes?	Y	P	N	Condyloma?	Y	P	N
Are you sexually active?	Y	N		Sexual difficulties?	Y	P	N
Perimenopausal symptoms?	Y	P	N	Age of menopause?	_____		
List:_____	_____						
Hysterectomy?	Y	N		Uterine, ovarian cancer?	Y	P	N
Perform breast self-exams?	Y	N		Breast lumps?	Y	P	N
Breast pain / tenderness?	Y	P	N	Nipple discharge?	Y	P	N
Breast cancer?	Y	P	N				

Personal Habits

Main interests and hobbies?_____

Do you exercise? Y N If yes, what kind?_____**How often?**_____

Do you have a religious or spiritual practice? Y N If yes, what?_____

Do you eat three meals a day?	**Y**	**N**	**Do you average 6-8 hrs/night sleep?**	**Y**	**N**
Do you sleep well?	**Y**	**N**	**Do you awaken rested?**	**Y**	**N**
Enjoy your work?	**Y**	**N**	**Spend time outside?**	**Y**	**N**
Watch television?	**Y**	**N**	**Read?**	**Y**	**N**
How many hours per day? _____			**How many hours per day?**_____		
Take vacations?	**Y**	**N**	**Any major traumas?**	**Y**	**P** **N**
Have a supportive relationship?	**Y**	**N**	**Have a history of abuse?**	**Y**	**P** **N**
Have you ever been treated for drug and/or alcohol dependency?				**Y**	**P** **N**
Use recreational drugs?	**Y**	**P** **N**	**Use alcoholic beverages?**	**Y**	**P** **N**
Amount per week _____			**Amount per week** _____		
Use tobacco?	**Y**	**P** **N**	**Number of years of tobacco use** _____		
If yes, how much per day?_____					
Drink coffee?	**Y**	**P** **N**	**Drink black tea?**	**Y**	**P** **N**
Drink cola or soft drinks?	**Y**	**P** **N**	**Do you eat sugar?**	**Y**	**P** **N**
Do you eat salt?	**Y**	**P** **N**	**Do you eat out often?**	**Y**	**P** **N**
Do you go on diets often?	**Y**	**P** **N**			

How does your condition affect you?_____

_____

What do you think is happening?_____

_____

Why?_____

_____

What do you feel needs to happen for you to get better?_____

_____

What do you enjoy most in your life?_____

_____

How much change are you willing to make, at this time, for improving your health?

Minimal **Some** **Complete**

Is there any other information about your health that you would like to add?_____