



Comprehensive Health History Form

Patient Information

Name _____ Date _____
 Address _____ City _____ State _____
 Zip _____ Home phone _____ Work phone _____ Cell _____
 E-mail _____ Have you had acupuncture before? () Yes () No
 Height _____ Weight _____ Age _____ Sex: () Male () Female Date of birth _____
 Occupation _____ Insurance ID Number: _____
 In emergency notify(name): _____ Emergency phone number: _____
 Marital Status: () Single () Married () Other
 Number of children: _____ Ages of children: _____
 Primary Care Doctor _____ Last seen: _____
 How did you hear about NFA clinic of Oriental Medicine: () A Talk () Article () Yellow Pages () Brochure
 () Business Card () Web site () Newspaper () Referred by: _____

Medical History

Reason for your visit here today: _____

 Are you being treated for this condition by anyone else: () Yes () No
 If Yes, who? _____ Phone number: _____
 Has this condition been diagnosed by a MD? () Yes (Diagnosis: _____) No ()
 Have these treatments helped? () Yes () Somewhat () Not much () Not at all
 How does this condition affect you? _____
 How long have you had this condition? _____
 Do you currently have any infectious diseases? () Yes () No () Possibly
 If Yes, please identify: () HIV+ () Hepatitis B () Hepatitis C () Flu/Cold () Streptococcus () Mononucleosis
 () Tuberculosis () Other: _____
 Known or suspected allergies: _____
 Childhood diseases you have had: () Chicken Pox () Measles () Mumps () Rheumatic Fever () Diphtheria
 () Scarlet Fever () Other: _____
 Physical or Emotional Traumas / Accidents / Hospitalizations / Surgeries in the past 10 years:

Reason	Date/Year(s)
_____	_____
_____	_____



Health Inventory

<p><u>Cardiovascular Conditions:</u> <input type="checkbox"/> A Pacemaker <input type="checkbox"/> Heart Disease <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Low Blood Pressure <input type="checkbox"/> Chest Pain <input type="checkbox"/> Palpitation <input type="checkbox"/> Stroke <input type="checkbox"/> Varicose Veins <input type="checkbox"/> Edema <input type="checkbox"/> Cholesterol</p>	<p><u>Emotional / Mental:</u> <input type="checkbox"/> Clinical Depression <input type="checkbox"/> Mild Depression <input type="checkbox"/> ADD or ADHD <input type="checkbox"/> Schizophrenia <input type="checkbox"/> Mood Swings <input type="checkbox"/> Panic Attacks <input type="checkbox"/> Nervousness <input type="checkbox"/> Anxiety <input type="checkbox"/> Alzheimer's <input type="checkbox"/> Dementia</p>	<p><u>Energy & Immunity:</u> <input type="checkbox"/> Meter Allergy <input type="checkbox"/> Chronic Fatigue Syndrome <input type="checkbox"/> General Fatigue <input type="checkbox"/> Slow Wound Healing <input type="checkbox"/> Easy Bruising <input type="checkbox"/> Chronic Infections <input type="checkbox"/> Frequent Allergies</p>	<p><u>Respiratory:</u> <input type="checkbox"/> Pneumonia <input type="checkbox"/> Asthma <input type="checkbox"/> Frequent Common Colds <input type="checkbox"/> Difficulty Breathing <input type="checkbox"/> Emphysema <input type="checkbox"/> Persistent Cough <input type="checkbox"/> Pleurisy <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Shortness of Breath</p>
<p><u>Musculo-Skeletal:</u> <input type="checkbox"/> Neck / Shoulder Pain <input type="checkbox"/> Muscle Spasms / Cramps <input type="checkbox"/> Arm Pain <input type="checkbox"/> Upper Back Pain <input type="checkbox"/> Low Back Pain <input type="checkbox"/> Ischioneuralgia <input type="checkbox"/> Leg Pain <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Arthritis <input type="checkbox"/> Joint Pain</p>	<p><u>Head, Eye, Ear, Nose & Throat:</u> <input type="checkbox"/> Impaired Vision <input type="checkbox"/> Eye Pain/Strain <input type="checkbox"/> Glaucoma <input type="checkbox"/> Glasses / Contacts <input type="checkbox"/> Tearing / Dryness <input type="checkbox"/> Impaired Hearing <input type="checkbox"/> Ear Ringing <input type="checkbox"/> Earaches <input type="checkbox"/> Ear Infections <input type="checkbox"/> Headaches <input type="checkbox"/> Sinus Problems <input type="checkbox"/> Nose Bleeds <input type="checkbox"/> Teeth Grinding <input type="checkbox"/> Frequent Sore Throats <input type="checkbox"/> TMJ / Jaw Problems <input type="checkbox"/> Hay Fever</p>	<p><u>Genito-Urinary Tract:</u> <input type="checkbox"/> Kidney Disease <input type="checkbox"/> Kidney Stones <input type="checkbox"/> Painful Urination <input type="checkbox"/> Dribbling Urination <input type="checkbox"/> Frequent UTI <input type="checkbox"/> Frequent Urination <input type="checkbox"/> Blood in Urine <input type="checkbox"/> Discharge <input type="checkbox"/> Incontinence</p> <p><u>Neurological:</u> <input type="checkbox"/> Vertigo / Dizziness <input type="checkbox"/> Paralysis <input type="checkbox"/> Numbness / Tingling <input type="checkbox"/> Loss of Balance <input type="checkbox"/> Seizures / Epilepsy <input type="checkbox"/> Dyslexia</p>	<p><u>Gastrointestinal:</u> <input type="checkbox"/> Stomach Ulcers <input type="checkbox"/> Changes in Appetite <input type="checkbox"/> Nausea / Vomiting <input type="checkbox"/> Epigastric / Abdominal Pain <input type="checkbox"/> Passing Gas <input type="checkbox"/> Heart Burn <input type="checkbox"/> Esophageal Reflux <input type="checkbox"/> Belching <input type="checkbox"/> Gall Bladder Disease <input type="checkbox"/> Gall Bladder Stones <input type="checkbox"/> Hemorrhoids <input type="checkbox"/> Constipation <input type="checkbox"/> Diarrhea</p>
<p><u>Endocrine:</u> <input type="checkbox"/> Hyperthyroid <input type="checkbox"/> Hypothyroid <input type="checkbox"/> Diabetes Type I <input type="checkbox"/> Diabetes Type II <input type="checkbox"/> Hypoglycemia <input type="checkbox"/> Night Sweats <input type="checkbox"/> Unusual Sweating <input type="checkbox"/> Feeling Hot <input type="checkbox"/> Feeling Cold <input type="checkbox"/> Cold Hand / Feet</p>	<p><u>Other:</u> <input type="checkbox"/> Cancer Type: _____ <input type="checkbox"/> Fibromyalgia <input type="checkbox"/> Lupus <input type="checkbox"/> Candida <input type="checkbox"/> Anemia <input type="checkbox"/> Rashes <input type="checkbox"/> Eczema / Hives <input type="checkbox"/> Atopic Dermatitis <input type="checkbox"/> Hemophilia</p>	<p><u>Liver Conditions:</u> <input type="checkbox"/> Hepatitis A <input type="checkbox"/> Hepatitis B <input type="checkbox"/> Hepatitis C <input type="checkbox"/> Cirrhosis of Liver</p>	<p><u>Men Only:</u> <input type="checkbox"/> Impotence <input type="checkbox"/> Vasectomy Date: _____ <input type="checkbox"/> Prostate problems <input type="checkbox"/> Testicular Pain / Redness / Swelling <input type="checkbox"/> Low libido <input type="checkbox"/> Excessive libido <input type="checkbox"/> Painful Intercourse <input type="checkbox"/> Seminal emissions</p>

Women Only:

Are you **pregnant right now?** () Yes () No () Trying () Maybe Method of Birth Control: _____
 Age of first period: _____ Date of last menses: _____ Age of menopause: _____
 Typical length of menses(days): _____ Typical length of cycle(from 1st day to 1st day of menses): _____
 Number of Pregnancies: _____ Births: _____ Abortions: _____ Miscarriages: _____
 Hysterectomy: () Yes () No If yes, date: _____
 Check all that apply: () Low libido () Excessive libido () Painful Intercourse () Clotting () **Painful Periods**
 () Heavy Flow () Scanty Flow () Bleeding Between Cycles () **Irregular Cycles** () Vaginal Discharge
 () Breast Lumps/Tenderness () Nipple Discharge () **Infertility** () **Menopausal Symptoms** () Premenstrual Problems



Medications

Please list all prescription and over the counter medications you are currently taking:

Drug Name	Reason for taking	For how long	Dose	Frequency

Please list all supplements and herbs you are currently taking:

Supplement	Reason for taking	Potency	Frequency

Lifestyle

(Daily amount used within the past 2 months)

Tobacco: ()Yes ()No Amount: _____ Alcohol: ()Yes ()No Amount: _____

Coffee: ()Yes ()No Amount: _____ Recreational Drug: ()Yes ()No Amount: _____

Do you feel you are at or near your ideal weight? ()Yes ()No

Do you feel you have enough energy? ()Yes ()No Are you vegetarian or vegan? ()Yes ()No

Best time of day(full of energy): _____ Worst time of day(least energy): _____

Favorite Season: _____ Hours of sleep / night: _____

Do you feel rested after a night sleep? _____ Do you remember your dreams? _____

Typical day's meals:

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks / Other: _____

Food cravings: _____

Religion or other spiritual practice: _____

Hobbies or other recreation: _____

What kind of physical exercise do you do regularly? _____

Hours of work per week? _____

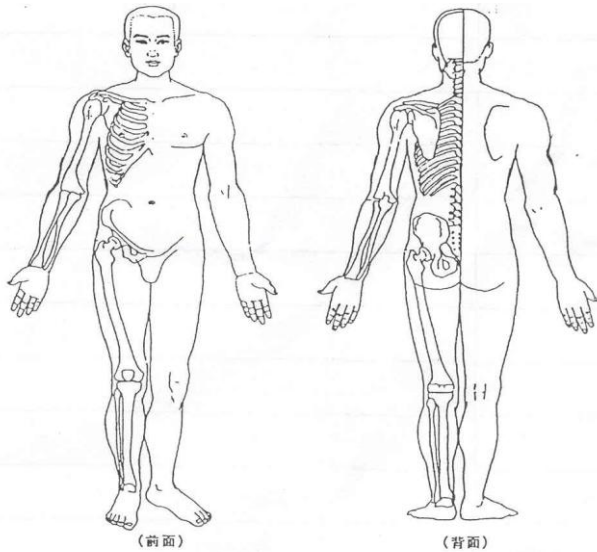
How would you rate your current stress level? ()Extreme ()Very High ()High ()Moderate ()Low



Please feel free to express any concerns or thoughts you feel may be relevant to your health below:

Use the diagram if desired.

How bad is your pain?	0	1	2	3	4	5	6	7	8	9	10	
	No pain											Unbearable pain



The Above information is true to the best of my knowledge. I understand and accept that I am responsible for full payment of my account and that payment is expected at the time of service. I also understand and accept that I am expected to notify NFA Clinic of Oriental Medicine **24** hours prior to any cancellations or changes to my appointment times and that if I do not I may be charged for the appointment.

X Signed: _____ Date: _____.

Parent / Guardian(if applicable) _____.

Would you like to receive a free email newsletter: ()Yes ()No