Lorene Harris Acupuncture

A Bodywise Acupuncture & Traditional Medicinals Clinic

Health History Intake

Welcome to the world of Acupuncture and Traditional Chinese medicine. In order to serve you in the best possible way, I need to be informed of your complete health history and updates. Please complete this form as thoroughly as possible. If something is not clear, indicate with a question mark. All information is held in confidence. Thank You.

Personal Information

Todays Date______

Name____ Phone_____________________

Address____ Other Phone________________

City____ State_______ Zip__________

Email____ May I contact email?_____________

How will you pay?____

Date of Birth____________________ Height________________ Weight____________________

Occupation____

Satisfaction with work:____

Spouse/partner name ____________________________ No. of children______ Ages:__________

Emergency Contact name:_________________________________ Phone___________________

Current Health Professional____

Have you ever had Acupuncture/Herbal Medicine/Shiatsu or Tui na?

How did you here about this practitioner?____

Current Condition

Primary reason for today's visit?____

____

____

____

How long have you had this condition?____

Is it getting worse?________ Does it interfere with work?_______Sleep?______Other?____________

What is the initial cause?____

What makes it worse?____

What makes it better?____

Have you been given a diagnosis for this condition? Yes No If so, what and by whom?

____

What treatments have you tried?

____

What medications are you currently taking? (prescription drugs, herbs, vitamins, etc.)

Date began	Drug/vitamin/supplement	Dose
___________	____________________________________	___________
___________	____________________________________	___________
___________	____________________________________	___________
___________	____________________________________	___________
___________	____________________________________	___________

Secondary Complaints

Please list any other health concerns or conditions:

Past Medical history

Please check all that apply and give dates

Cancer____________________
Asthma___________________
Pneumonia________________
Diabetes__________________
Heart Disease_____________
HIV/AIDS__________________
Hepatitis__________________
Rheumatic Fever___________
Drug/Alcohol Addiction______
High/Low Blood Pressure___
Thyroid Disease____________
Frequent Colds/Flus________
Rate________________
Seizures__________________
Bronchitis__________________

Allergies(describe)____

Other (describe)____

Surgeries, serious illness, physical traumas

Date	Describe

Emotional Trauma

Date	Describe

Please List any major diseases, illnesses, deaths and their causes of family members:

Date	Describe

Lifestyle

Please check all that apply and describe:

Tobacco use________________________________
Alcohol____________________________________
Coffee/Tea_________________________________
Soft drinks_________________________________
Laxatives__________________________________
Aspirin or Pain Medication___________________

Therapy/Counseling__________________________
Exercise____________________________________
Meditation__________________________________
Stress______________________________________
Occupational hazard__________________________
Other______________________________________

General Health

Please **Check** or **Circle** all that apply

Appetite: Low___ Normal____ High_____

Diet: Standard_____ No red meat___ Lacto-vegetarian_____Vegetarian____Vegan__Other___

Taste craving: Sweet _____Salty_____Spicy_____Bitter_____Sour_____ No Craving_____

Tend to feel Cold_____Hot_____Normal_____All over_____Extremities Only_____

Emotion: Fear_____Joy_____Anger_____Grief/Sadness_____Worry/Guilt/Obsessing_____

Other____

Heavy Sleep	Fever	Bleed/bruise easily	Lymphatic swelling
Falling asleep	Chills	Weight loss	Varicose Veins
Staying asleep	Night Sweats	Weight gain	Prefer cold drinks
Disturbing sleep	Sweat easily	Peculiar Smell/Taste	Prefer hot drinks
Fatigue	Tremors	Edema	Sudden Energy drop

Musculoskeletal

Neck Pain	Hip Pain	Hand/WristPain	Swollen Joints
Shoulder Pain	Knee Pain	General Muscle Pain	Numbness
Back Pain	Foot/Ankle Pain	Muscle Weakness	Tremors

Cardiovascular

Heart Palpitations	Irregular Heartbeat	Blood Clots	Cold Hands/Feet
Chest Pain	Fainting	Swelling of Hands/Feet	Hot Hands/Feet

Respiratory

Difficulty Breathing	Tight Chest	Cough	Pneumonia
Shortness of Breath	Weak Voice	Congestion	Frequent Infections

Gastrointestinal

Nausea	Belching	Hemorrhoids	Disinterest in Eating
Vomiting	Hiccups	Stomach Acid	Abdominal Pain/Cramps
Diarrhea/Constipation	Indigestion	Low Body Weight	Abdominal Bloating
Gas	bad Breath	Frequent Desire to eat	Gurgling in Stomach

Neurological, Psychological

Seizures	Lack of Coordination	Anxiety	Indecisive
Dizziness	Poor Memory	Irritable	Fearful
Loss of Balance	Concussion	Have Anger	Easily Stressed
Areas of Numbness	Depression	LoseTemper Easily	Thoughts of Suicide

Head, Eyes, Ears, Nose, Throat

Wear Glasses	Eye Strain	Ringing in the Ears	Facial Pain
Night Blindness	Eye Pain	Poor Hearing	Sores on Lips/Mouth
Color Blindness	Dry Eyes	Sinus Problems	Teeth Problems
Cataracts	Migraines	Nose Bleeds	Jaw Clicks
Spots in front of eyes	Headaches	Reoccurring Sore throat	Dry Mouth
Blurry Vision	Ear Aches	Grinding Teeth	Excessive Saliva

Skin and Hair

Dry Skin & Hair	Oily Skin/Hair	Skin Rash	Psoriasis
Dandruff	Acne/Pimples	Itching	Recent Moles
Loss of Hair	Open Sores on Skin	Eczema	Cysts/Tumors

GenitoUrinary

Frequent Urination	Painful Urination	Unable to Hold Urine	STDs____________
Waking Up to Urinate	Decrease in Urination	Blood in Urine	Reduced Sex Drive

Women

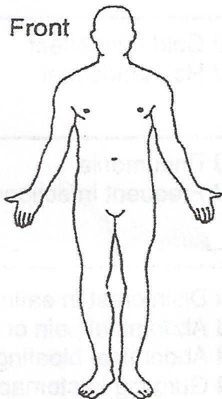
Age of First Menses__	Blood Clots	Peri-Menopausal	Miscarriages #____
Heavy Menses__days	Ovarian Cysts	Menopause at Age__	Abortions #_______
Light Menses__days	Yeast Infections	Pregnancies #___	Currently Pregnant
Irregular Menses	Endometriosis	Live Birth #_______	# of Month______
Painful Menses	Infertility	Premature Birth #___	
PMS____days	Hysterectomy	C-Section Deliveries	

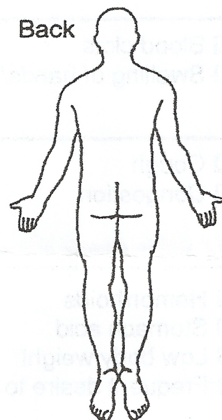
Men

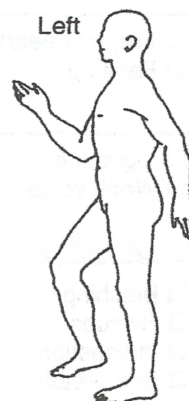
Erectile Dysfunction	Premature Ejaculation	Painful/Swollen Testicles	Painful Ejaculation
Prostatitis	Nocturnal Emissions	Performance Anxiety	

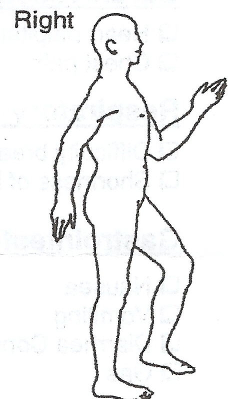
Areas of Pain

Please mark all painful areas









Additional Comments

Please provide any additional important information which has not already been covered above: