Daniel L. Altschuler L.Ac. **Health History Form**

Today's date M______D_______Y_______

Name____ Nickname______________________________

Phone (H) _________________ (W)______________________ (C)_____________________________________

Address ____

City _______________ State ______ Zip _________________E-mail ________ ___________________________

Age ________ Date of Birth M______D_______Y_______Place of Birth_________________________________

Height _________ Weight __________ Marital/Partnership Status ______________________________

Profession___________________________________

Family Physician ______________________________ Referred By ___________________________________

Emergency Contact ____ Phone___________________________

Have You Been Treated By Acupuncture or Oriental Medicine Before? Yes ☐ No ☐

Main Problem(s) you would like help with ____

____

How long ago did this problem begin (be specific)? ____

____

To what extent does this problem interfere with your daily activities (work, sleep, etc)? ________________

____

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

____

What kinds of treatment have you tried? ____

____

Past Medical History (please include date): Cancer _________ Diabetes ________ Hepatitis ___________

Blood Pressure High/Low ______/______ Heart Disease _______ Rheumatic Fever____________________

Thyroid Disease _________Seizures _______ STDs_______________________ HIV/AIDS ______________

Other ____

Surgeries (type of and date)____

____

Significant Trauma (auto accidents, falls, etc) ____

____

Significant Dental Work (type and date)____

Allergies (drugs, chemicals, foods/result) ____

Family Medical History (check): Diabetes ☐ Cancer ☐ High Blood Pressure ☐

Heart Disease ☐ Stroke ☐ Seizures ☐ Asthma ☐ Allergies ☐

Other ☐____

Medicines taken within the last two months (vitamins, drugs, herbs, etc)

Name of Medication/Supplement	Reason for Taking It
______________________________	__________________________________
______________________________	__________________________________
______________________________	__________________________________
______________________________	__________________________________
______________________________	__________________________________
______________________________	__________________________________
______________________________	__________________________________
______________________________	__________________________________
______________________________	__________________________________

Occupational Stress (physical, chemical, psychological, etc) ____________________________________

____

Do you have a **regular exercise program**? Yes ☐ No ☐ Please Describe ___________________

____

Have you ever been on a **restricted diet**? Yes ☐ No ☐ What Kind? ______________________

____

Are you a smoker? Yes ☐ No ☐ Quit ☐

If so, how many **packs of cigarettes** do you smoke per day? _____/day

How many caffeinated beverages (**coffee, cola**, **energy drinks**) do you drink per day? _______________

How much **alcohol** do you drink per week? ____

Please describe any use of recreational drugs ____

Please check any problems you have had in the last three months:

General
- ☐ Poor appetite
- ☐ Fevers
- ☐ Sweat easily
- ☐ Localized weakness
- ☐ Bleed or bruise easily
- ☐ Peculiar tastes or smells
- ☐ Strong thirst (cold or hot)
- ☐ No desire to drink
- ☐ Sudden energy drop
  When? ________________
- ☐ Poor sleep
- ☐ Chills
- ☐ Tremors
- ☐ Poor balance
- ☐ Fatigue
- ☐ Night sweats
- ☐ Cravings
- ☐ Change in appetite
- ☐ Weight gain
- ☐ Weight loss

Skin and Hair
- ☐ Rashes
- ☐ Itching
- ☐ Dandruff
- ☐ Change in hair or skin
- ☐ Ulcerations
- ☐ Eczema
- ☐ Loss of Hair
- ☐ Hives
- ☐ Pimples
- ☐ Recent moles
- ☐ Other hair or skin problems

____
____

Musculoskeletal
- ☐ Muscle pain
- ☐ Muscle weakness
- ☐ Neck pain
- ☐ Shoulder pain
- ☐ Hand/wrist pain
- ☐ Back pain
- ☐ Hip pain
- ☐ Knee pain
- ☐ Foot/ankle pain

Head, Eyes, Ears, Nose, and Throat
- ☐ Dizziness
- ☐ Poor vision
- ☐ Cataracts
- ☐ Eye strain
- ☐ Night blindness
- ☐ Blurry vision
- ☐ Spots in front of eyes
- ☐ Eye pain
- ☐ Color blindness
- ☐ Earaches
- ☐ Ringing in ears (tinnitus)
- ☐ Poor hearing
- ☐ Sinus problems
- ☐ Grinding teeth
- ☐ Teeth problems
- ☐ Jaw clicks
- ☐ Facial pain
- ☐ Nose bleeds
- ☐ Recurrent sore throats
- ☐ Sores on lips or tongue
- ☐ Concussions
- ☐ Migraines
- ☐ Headaches - where and when ________________
  ____
- ☐ Other head or neck problems ______________
  ____

Cardiovascular
- ☐ High blood pressure
- ☐ Irregular heartbeat
- ☐ Cold hands or feet
- ☐ Blood clots
- ☐ Low blood pressure
- ☐ Dizziness
- ☐ Swelling of hands
- ☐ Swelling of feet
- ☐ Phlebitis
- ☐ Chest pain
- ☐ Fainting
- ☐ Difficulty in breathing
- ☐ Other heart or blood vessel problems ______________
  ____

Respiratory
- ☐ Cough
- ☐ Bronchitis
- ☐ Pneumonia
- ☐ Asthma
- ☐ Tuberculosis
- ☐ Pain with a deep breath
- ☐ Difficulty in breathing when lying down
- ☐ Production of phlegm
  what color _____________
- ☐ Coughing blood
- ☐ Other lung problems _____
  ____
- ☐ Approximately when was your last cold or flu?________
  ____

Gastrointestinal
- ☐ Nausea
- ☐ Constipation
- ☐ Diarrhea
- ☐ Chronic laxative use
- ☐ Bad breath
- ☐ Belching
- ☐ Burning sensation
- ☐ Abdominal pain or cramps
- ☐ Vomiting
- ☐ Gas
- ☐ Indigestion
- ☐ Blood in stools
- ☐ Black stools
- ☐ Rectal pain
- ☐ Rectal burning
- ☐ Anal Prolapse
- ☐ Hemorrhoids
- ☐ Other stomach or intestinal problems _______________
  ____

Pregnancy and Gynecology

Number of pregnancies ____
Number of births __________
Premature births __________
Miscarriages ______________
Abortions ________________
Age at first menses ________
Days between menses _____
Duration _________________
First day of last menses ____
____

- Unusual character (heavy or light)
- Painful periods
- Vaginal discharge
  What color?____________
- Changes in body/psyche prior to menstruation
- Clots
- Vaginal sores
- Irregular periods
- Last Pap ______________
- Breast lumps
- Fibroid Cysts
- Are you sexually active?__

Do you practice birth control?

 Yes No N/A

What type and for how long?
____

- Other Gynecology related concerns_________________

____
____

Genito-urinary

- Pain on urination
- Urgency to urinate
- Frequent urination
- Unable to hold urine
- Urinary difficulty
- Impotency
- Blood in urine
- Kidney stones
- Sores on genitals
- Other genital or urinary system problems ________

____

- Do you wake up to urinate?

 Yes No

How often?
____

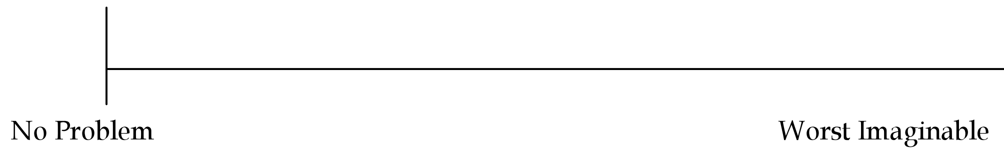
Any particular color to your urine? ________________

Neuropsychological

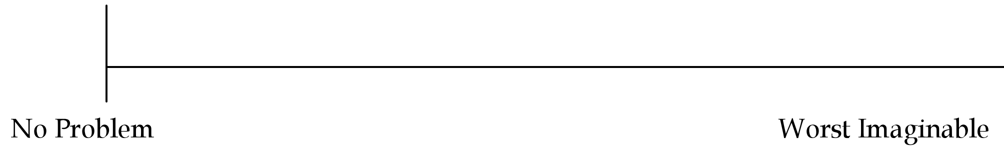
- Seizures
- Stroke
- Tremors
- Fainting spells
- Areas of numbness
- Concussion
- Poor memory
- Dizziness
- Vertigo
- Loss of balance
- Lack of coordination
- Depression
- Easily stressed
- Bad temper
- Anxiety
- Difficulty concentrating
- Other neurological or psychological concerns

____
____

Please note the severity of your main problem now:



Please note the severity of your main problem within the last week:



Comments (please mention any other problems or concerns you would like to discuss)

Indicate painful or distressed areas