Peri Ozker Acupuncture

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Health History Form

All information gathered on this form is held in the utmost confidence and released only with your permission. Although aspects of these questions may seem unrelated to your main complaint, and may be quite personal, they are clinically significant to make an accurate and complete diagnosis within Asian medicine. Thank you for filling this form out carefully and completely, as it will ultimately provide you with the best possible care and results.

Patient Name _____ Date _____

Full Address _____Zip_____

Date of Birth_____ Age____ Occupation_____

Phone: Home_____Cell:_____ Work:_____

E-mail_____ Relationship/Marital Status _____

(best way to contact you, if needed: please circle email/cell/work/home)

Referred by_____ May we thank this person? yes/no

Emergency contact (name/phone)_____

What is your main complaint?_____
_____
_____
_____

Date main complaint started?_____

How frequently does this problem bother you? ____X daily/weekly/monthly/every day/all the time or other description: _____

When it is bothering you, how long does each episode last? _____

How severe is the **intensity** on a scale of 0-10: best = 0 to 10 = worst

when symptom is best = _/10, when symptom is worst = _/10, Today =_/10

What Activities of Daily Life ADL cause you the most concern as affected by the main complaint? work/sleep/home/social/sex/sports/other (please be specific):_____
_____

If there is pain, what is the pain **quality**? Circle all that apply:

Dull/achey Burning sharp/stabbing Cold Numb Traveling Gripping Throbbing
Bones hurt Spasms Other_____

What makes the pain/symptom better or worse? Circle all that apply:

Heat Cold Damp Weather Wind Rest Work Movement Sitting Lying Touch/Pressure
Stress Weekends Medications/NSAIDS/_____

Have you received a diagnosis for this? If so, what? _____
_____

What kinds of treatments have you tried for this? _____
_____

Please list any allergies:(drugs, chemicals, food, environmental, herbs)_____
_____
_____

Please list any current medications, vitamins, herbs, homeopathics _____
_____
_____

Do you exercise regularly? yes/no Activity and frequency? _____
_____

Do you smoke or use tobacco products? yes/no/used to If so, how much? _____

How much coffee, tea, cola drinks to you consume? _____per week/day

How much alcohol do you consume? _____per week/day

Do you use any recreational drugs? What kind? _____

Energy level How is your overall energy? (if 0 = low to 10= high/best ever) ____/10

How is it after exercise? better/worse/same How is it after meals? better/worse/same

How is it after a bowel movement? better/worse/same

Do you feel quite tired or have fatigue? When—circle below:

morning afternoon after work if weather is damp/humid

Thirst How much WATER do you drink a day? _____

Other liquids? _____

Are you thirsty frequently? yes/no Do you have thirst but no desire to drink? yes/no

Do you prefer to drink (circle, if any) cold/iced/room temperature/hot liquids?

Appetite How is your appetite? _____

Do you notice an unusual taste in your mouth? yes/no, if so, what?_____

Do you have any sensation of feeling 'weighed down' or heaviness in your body? yes/no

Have you gained or lost weight in the last 6-12 months? Describe _____

Cravings Do you have any tendency to crave any of these flavors: please circle all that apply

sweets sour bitter spicy salty hot cold fried

Hot/Cold Do you notice you tend to feel (circle one)

hotter than others colder than others generally comfortable

only my feet only my hands both hands and feet elsewhere_____

Past Medical History: (please circle all that apply and include dates or age)

Significant illness: cancer diabetes hepatitis high blood pressure VD HIV EBV Hepatitis

heart disease rheumatic fever thyroid disease seizures autoimmune disorders

Candida(yeast) Other and/or dates _____

_____

Family Medical History: diabetes cancer high blood pressure mental illness alcoholism
heart disease seizures asthma allergies autoimmune disease stroke arthritis
other: _____
_____

Surgeries (please indicate dates or age): _____
_____
_____

Significant trauma (auto accidents, falls, etc; please indicate dates or age):_____
_____
_____

Have you received cortisone injections or taken oral corticosteroids? yes/no_____
if yes, when/what for/how long_____

Have you ever been on a restricted diet? yes/no if yes: what kind? _____

Currrent Health: Please note/circle any items you have experienced in last 3 months

General:
__poor appetite __poor sleep __fatigue __tremors __fevers __chills __night sweats
__sweats easily __cravings __bruise easily __localized weakness __poor balance

Skin/Hair: __rashes __ ulceration __hives __itching __eczema __pimples/acne
__dandruff __hair loss __new moles __other changes:_____

Musculoskeletal: __neck pain __shoulder pain __muscle pains __knee pain __back pain
__hip pain __foot/ankle pain __muscle weakness __hand/wrist pain
other joint or bone problem_____
_____

Head/Eyes/Nose/Throat:

Headaches (yes/no):
frequency: _____X per day/week/year duration _____
location: temples/behind eye/top/back/sinus/other_____
one-sided: yes/no/alternates on _____ side
severity of pain (best = 0 to worst = 10) today __/10
pain at its best __/10 at its worst __/10

Headaches (cont):

Is the pain: __dull achey __sharp stabbing __throbbing __moving __heavy
Is it better/worse/neither with pressure applied to headache area? Please circle
Is it worse with improper diet/morning/evening/bright light/noise? Please circle
Do they come at a certain time of day? yes/no if yes, when_____
Do they occur before/during/after your period?
Do they occur only during the week/weekends?

Please circle any of the other following <u>head/eyes/ear/throat</u> symptoms: dizziness concussions

migraines eye strain eye pain poor vision night blindness color blindness cataracts

'floaters'/spots in vision ringing in ears(pitch high/low) sinus problems nose bleeds

recurrent sore throats grinding teeth facial pain bleeding gums

lip/tongue sores teeth concerns jaw clicks wear glasses/contacts

other_____

<u>Cardiovascular</u>:

low/high blood pressure chest pain/pain down arm irregular heartbeat dizziness

fainting cold hands/feet swelling of hands/feet blood clots phlebitis

varicose veins spider veins palpitations other_____

<u>Respiratory</u>:

shortness of breath difficulty breathing cough asthma bronchitis pneumonia

recurrent colds/flu blood/phlegm in cough other_____

<u>Gastrointestinal (digestion and bowels)</u>:

nausea vomiting loose stools/diarrhea constipation gas belching/hiccups

indigestion bloating after meals abdominal pain/cramps eating disorders

acid reflux/heartburn hemorrhoids ulcer longterm antibiotic use

long term laxative use history parasites

Any other stomach, digestive, intestinal concerns:_____

How often do you move your bowels? _____ times per day/week

Is the consistency of your stool typically: loose-diarrhea hard-constipated
watery formed thin alternating loose-constipated

<u>Urinary:</u>

Do you wake at night to urinate? yes/no how often_____

Upon urination have you noticed any: pain blood urgency increased frequency

smell unable to hold urine color do you take vitamins?yes/no

scanty/copious volume other concerns_____ p4/6

Men's Reproductive and Sexual Health:

libido(sex drive): decreased increased other concerns/questions

erectile concerns prostate problems genital sores fertility concerns

other concerns or questions:_____

Women's Reproductive and Sexual Health:

libido (sex drive): decreased increased other concerns/questions

Age of first period____years old #days your period lasts_____

Is your cycle regular/irregular/absent? Duration of cycle____days/cycle

Your most recent period of bleeding was (date) _____

Please be specific with your period: light/moderate/heavy flow

clots pale/red/purple/dark blood cramps are before/during/after flow

PMS with irritability/mood swings/weepy/depressed/ other _____

breast tenderness, which is heavy/swollen/cysts/other_____

pain (before/during/after period) which is sharp-stabbing/dull-achey/other_____

pain severity: ___/10(worst) any back pain with period:yes/no____

pain is better with: heat cold touch resting movement medication

pain is worse with: heat cold touch resting movement medication

Are you perimenopausal/menopausal?(circle one) Are you sexually active? yes/no

Do you use birth control/hormone replacement? yes/no, and what kind_____for how long _____

Vaginal dryness/discharge/pain/sores/STD's describe_____

Breast changes with period: tender/hard/swollen/hot/cysts/other_____

Women's Obstetric History: Number of pregnancies____ Number of births____

Have you experienced: premature births miscarriage(s) early termination/abortion(s)

Have you experienced fertility issues?_____
If so, have you received a diagnosis?_____

Neuro-psychological: (please circle all that apply) seizures dizziness PTSD

loss of balance/coordination numbness poor memory easily stressed

concussion depression anxiety bad temper/road rage ADD/ADHD/related

Have you received care/treatment for psycho-emotional problems? _____

Have you ever had suicidal tendencies or attempts? _____ p5/6

Personal:

Are you currently experiencing any significant family/household stress? _____

_____

In the past 12 months, have you experienced a significant loss? (serious illness or death in the family/household/pet, job loss, miscarriage, separation, divorce, other)? _____

_____

Do you feel actively supported by your friends/family?_____

Do you own pets? _____ Do you consider your home life stressful? _____

Emotions and Personality:

What is your overall stress level (low = 0 to high = 10) ___/10

Job __/10 Home:__/10 Spouse/partner relationship: __/10

What aspects of your life are most pleasurable and reduce your stress?

_____

How do you describe yourself? _____

How might others describe you? _____

When angry, are you most likely to:

express it/ repress it/ burst out/ be irritable/ isolate self / rib or side pain

other_____

With regard to your main complaint, what was going on in your life when it first began?

_____

What is your feeling or 'intuitive' sense, if any, as to what 'caused/is causing' the main complaint?_____

Please add any comments or questions you wish here:

*****Thank you again for your careful consideration of this questionaire*******
Peri Ozker, Licensed Acupuncturist