Eastwind Acupuncture and Tuina Healing Center

Patient Health History Form

General Information

Date:_________ Name:____ Gender: Female/Male
First MI Last (Please circle)

Date of Birth:______/______/______ Age:_______ Marital Status:_____________ No. of children_____________

Address:____ City:__________ State:_____ Zip:________

Phone Numbers: H-(____)_________________ W-(____)_________________ C-(____)__________________

Social Security No.:______________________________ Email:______________________________________

Employer:_____________________________ Occupation:______________________ Title:_________________

Height: ________Feet _________Inches Weight: _________lbs.

Emergency Contact Information

Name: ___________________________ Relationship: ____________ Phone Number:________________________

Referred by:____

Please identify your health concerns.
(If your concern is pain related, please rate the level of pain using a scale from 0 to 10, with 10 being the worst.)
Primary:____ Pain Scale:__________
When did you first notice the problem?____

Secondary:____ Pain Scale:__________
When did you first notice the problem?____

Tertiary:____ Pain Scale:__________
When did you first notice the problem?____

Medical History
Are you currently taking any blood thinner medication? Y/N Do you have a tendency to bleed? Y/N
Please check any condition that applies.

☐Migraine Headaches	☐TMJ (jaw pain)	☐Allergies (specify types) ________________
☐Asthma	☐Arthritis (osteoarthritis)	☐Rheumatoid Arthritis
☐High Blood Pressure	☐High Cholesterol	☐Heart Attack
☐Congestive Heart Failure	☐Stroke	☐**Pacemaker**
☐Diabetes (type I or II)	☐Anemia	☐**Hemophilia**
☐Hepatitis	☐HIV/AIDS	☐Cancer/Tumor(specify types)____________
☐Irritable Bowel Syndrome	☐GI Ulcers	☐Gastritis
☐Depression/Anxiety	☐Insomnia	☐Panic Attack
☐Bipolar	☐Borderline Personality	☐Eating disorder
☐Fibromyalgia	☐Epilepsy	☐Chemical Dependency
☐Multiple Sclerosis	☐Systemic Lupus	☐Thyroid Disease: (Hyper or Hypo)

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Name:____________________________

Other: (specify)____

Other: (specify)____

General Symptoms

1. How is your energy level? ☐good ☐low (morning/afternoon/evening/through out the day)
2. Do you have any sleep problem? Y/N If yes, please check ones that apply.
   ☐Trouble falling asleep ☐Wake up a lot ☐Wake up early and cannot go back to sleep
   ☐Nightmares/vivid dreams ☐Snoring ☐Sleep apnea
3. How does your body feel temperature-wise in general? (Check only one)
   ☐Cold ☐Warm ☐Cold on extremities ☐Neither
4. What temperature of fluid do you usually drink? (Check only one)
   ☐Cold/icy ☐Room temperature ☐Warm ☐Mix cold and warm
5. Have you noticed any sweating pattern? (Check ones that apply)
   ☐Spontaneous sweating ☐Night sweats ☐Don't usually sweat ☐Other:________________
6. How often do you get thirsty?
   ☐Always thirsty ☐Sometimes ☐Not usually
7. Have you noticed any special taste in the mouth? Y/N If yes, please describe______________________________
8. Please describe your appetite____

Please check the following GI symptoms you **often** encounter.

☐Bloating ☐Belching ☐Gas ☐Acid Reflux ☐Nausea ☐Vomiting ☐Constipation
☐Hard stools ☐Loose stools ☐Watery stools ☐Hemorrhoids ☐Abdominal cramps

For female patient only

1. Do you have any menstrual problem? Please briefly describe____
____
2. No. of pregnancy__ No. of living children__ No. of miscarriage and stillborn__

Past Medical History

Please list any major event including surgery, trauma, hospitalization, etc., and the year of the event.

1.______________________________________ 2. ______________________________________
3. ______________________________________ 4. ______________________________________
5.______________________________________ 6. ______________________________________

Family Medical History (please indicate on which side of your parents.)

1.______________________________________ 2. ______________________________________
3. ______________________________________ 4. ______________________________________

Medication List

Please list any medications, vitamins, or supplements which you are currently taking.

1. Name:_________________________ Dosage:___________ Purpose:______________________________________
2. Name:_________________________ Dosage:___________ Purpose:______________________________________
3. Name:_________________________ Dosage:___________ Purpose:______________________________________
4. Name:_________________________ Dosage:___________ Purpose:______________________________________
5. Name:_________________________ Dosage:___________ Purpose:______________________________________
6. Name:_________________________ Dosage:___________ Purpose:______________________________________
7. Name:_________________________ Dosage:___________ Purpose:______________________________________
8. Name:_________________________ Dosage:___________ Purpose:______________________________________

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