BODY WELLNESS CENTER
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HEALTH HISTORY

Please help us provide you with a complete evaluation by taking the time to fill out this questionnaire carefully. All of your answers will be held absolutely confidential. If you have questions, please ask. If there is anything you wish to bring to our attention which is not on this form, please note in the comments section. Thank You.

Name:______________________________________ Date:________________________

Address:____

City:_____________________________ State:_______ Zip:_______________________

Home Phone:_______________________ Work Phone:____________________________

Mobile Phone:______________________ E-Mail:_________________________________

Marital Status:_______________ Date of Birth:____________ Age:_______________

Physician:________________________________ Phone:__________________________

In Emergency Notify:______________________ Phone:__________________________

Referred By:_________________________ Occupation:___________________________

Have you been treated by acupuncture or Oriental medicine before? _________________

Main Complaint (symptoms, diagnosis, duration, etc.)_____________________________

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What kinds of treatments have you tried?_____________________________________

____

Significant Trauma (physical or emotional)______________________________________

Allergies (chemicals, foods, drugs)____

____

Medications (please attach additional pages if necessary)__________________________

____

Surgeries (please include date of procedure)_____________________________________

____

Your Birth History (prolonged labor, forceps delivery, etc)________________________

Exercise (type of activity, days per week, length of workout)_____________________

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Diet (meals per day, caffeinated drinks, alcohol per week)_________________________

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Personal Medical History Please check any conditions or symptoms you have now.

☐ Cancer	☐ Diabetes	☐ Seizures
☐ Stroke	☐ Heart Disease	☐ Thyroid Disease
☐ Hepatitis	☐ High Blood Pressure	☐ Other_________________

Family Medical History Please check any condition that applies to your immediate family.

☐ Cancer	☐ Diabetes	☐ Seizures
☐ Stroke	☐ Heart Disease	☐ High Blood Pressure
☐ Allergies	☐ Asthma	☐ Other_________________

Please check if you had any of these items listed below in the last 3 months.

General

☐ Poor Sleeping	☐ Night Sweats	☐ Fatigue
☐ Sweats Easily	☐ Weight Loss	☐ Cravings
☐ Change in Appetite	☐ Weight Gain	☐ Fevers
☐ Sudden Energy Drop	☐ Bleed/Bruise Easily	☐ Poor Appetite
☐ Peculiar Tastes or Smells	☐ Dental problems	☐ Strong Thirst (hot or cold)

Skin and Hair

☐ Rashes
☐ Dandruff
☐ Recent Moles
☐ Warts
☐ Itching
☐ Eczema
☐ Loss of Hair
☐ Ulcerations
☐ Hives
☐ Acne
☐ Change in skin/hair texture
☐ Skin Discoloration

Head, Eyes, Ears, Nose and Throat

☐ Dizziness
☐ Eye Strain
☐ Blurry Vision
☐ Spots in Front of Eyes
☐ Poor Hearing
☐ Nose Bleeds
☐ Headaches
☐ Dental Problems
☐ Migraines
☐ Poor Vision
☐ Night Blindness
☐ Glasses
☐ Grinding Teeth
☐ Sinus Problems
☐ Jaw Clicks
☐ Recurrent sore throats
☐ Eye Pain
☐ Cataracts
☐ Color Blindness
☐ Ringing in the Ears
☐ Facial Pain
☐ Earaches
☐ Sores on Lips/Tongue
☐ Difficulty Swallowing

Cardiovascular

☐ Low Blood Pressure
☐ Cold Hands/Feet
☐ Swelling of Hands/Feet
☐ Blood Clots
☐ Chest pain or Pressure
☐ Palpitations
☐ Shortness of Breath
☐ Fainting
☐ Irregular Heart Beat
☐ Varicose/Spider Veins
☐ Spontaneous Sweating
☐ Phlebitis

Respiratory

☐ Cough/Wheezing
☐ Pneumonia
☐ Pain with Deep Inhalation
☐ Coughing Blood
☐ Asthma
☐ Production of Phlegm..if so what color?______________
☐ Bronchitis
☐ Difficult Breathing

Gastrointestinal

☐ Nausea
☐ Diarrhea
☐ Indigestion
☐ Rectal Pain
☐ Bad Breath
☐ Hernia
☐ Vomiting
☐ Gas
☐ Blood in Stools
☐ Hemorrhoids
☐ Bloating/Edema
☐ IBS/Crohn's Disease
☐ Constipation
☐ Belching
☐ Black Stools
☐ Chronic Laxative Use
☐ Acid Reflux
☐ Abdominal Pain/Cramps

Genito-Urinary

- ☐ Pain Upon Urination
- ☐ Frequent Urination
- ☐ Kidney Stones
- ☐ Decreased Libido
- ☐ Herpes
- ☐ Urgency to Urinate
- ☐ Blood in Urine
- ☐ Unable to Hold Urine
- ☐ Urinary Tract Infection
- ☐ Prostatitis
- ☐ Decrease in Flow
- ☐ Sores on Genitals
- ☐ Impotence
- ☐ Dribbling after Urination
- ☐ Night Urination

Gynecological/Reproductive

- ☐ Painful Periods
- ☐ Irregular Menstruation
- ☐ Endometriosis
- ☐ Vaginal Sores
- ☐ Polycystic Ovarian Disease
- ☐ Fibrocystic Breast Tissue
- ☐ Vaginal Discharge
- ☐ Ovarian Cysts
- ☐ Infertility
- ☐ Vaginal Dryness
- ☐ Uterine Fibroids
- ☐ Number of Abortions___
- ☐ Age of first Menses_____
- ☐ Date of last Menses_____
- ☐ Date of last PAP________
- ☐ Number of Pregnancies__
- ☐ Number of live Births____
- ☐ Number of Miscarriages__

Musculoskeletal

- ☐ Back Pain
- ☐ Hip Pain
- ☐ Bursitis
- ☐ Hand/Wrist Pain
- ☐ Carpal Tunnel
- ☐ Knee Pain
- ☐ Shoulder Pain
- ☐ Sprains/Strains
- ☐ Foot/Ankle Pain
- ☐ Rotator Cuff
- ☐ Neck Pain
- ☐ Sciatica
- ☐ Muscle Pain
- ☐ Tendonitis
- ☐ Muscle Weakness

Neuropsychological

- ☐ Seizures
- ☐ Anxiety/Panic attacks
- ☐ Depression
- ☐ ADD?ADHD
- ☐ Concussion
- ☐ Vertigo/Dizziness
- ☐ Loss of Balance
- ☐ Poor Memory
- ☐ Nervousness
- ☐ Easily Susceptible to Stress
- ☐ Lack of Coordination
- ☐ Areas of Numbness
- ☐ Bad Temper/Irritability
- ☐ Manic Depression

Have you ever been treated for emotional problems?_________________
Have you ever considered or attempted suicide?____________________
Have you ever been treated for substance abuse?___________________

Comments Please inform us of any other problems you would like to discuss.

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