Wisdom Ways Acupuncture

363 W. Drake Suite 1, Fort Collins, CO 80526 Phone (970) 227-3077

Patient Health History

Name: _____ Date: _____/_____/_____
(first) (middle) (last)

Date of Birth: _____/_____/_____ Age: _____ Gender: M/F Marital status: S M D W

Successful health care and preventative medicine are only possible when the practitioner has a complete understanding of the patient physically, mentally, and emotionally. Please complete this questionnaire as thoroughly as possible. Print all information and indicate areas of confusion with a question mark. Thank you.

1. When and where did you last receive health care_____

For what reason? _____

2. How did you find out about us? _____ Can we thank them for the referral? Y N N/A

3. Please identify the health concerns that have brought you to the Wisdom Ways Acupuncture Clinic, in order of importance below:

Condition	**Past Treatment**
a. _____	_____

*What do you believe caused this condition?*_____

How hopeful do you feel about this condition resolving? ____Very _____Somewhat _____Not very ___Not at all

Are you willing to make changes to help resolve this condition? ____Definitely _____Perhaps ____Probably Not

b. _____ _____

*What do you believe caused this condition?*_____

How hopeful do you feel about this condition resolving? ____Very _____Somewhat _____Not very ___Not at all

Are you willing to make changes to help resolve this condition? ____Definitely _____Perhaps ____Probably Not

c. _____ _____

*What do you believe caused this condition?*_____

How hopeful do you feel about this condition resolving? ____Very _____Somewhat _____Not very ___Not at all

Are you willing to make changes to help resolve this condition? ____Definitely _____Perhaps ____Probably Not

4. If applicable, please list any foods, drugs, or medications to which you are allergic (please include reaction):

_____

_____

5. **Please list any medications (prescribed and over-the-counter), vitamins, and supplements you are currently taking:**

_____

_____

_____

6. Do you have any reason to believe you may be pregnant? Y N

If so, how far along are you? _____

7. Do you have any infectious diseases? Y N If yes, please identify: _____

8. Family History: Check those applicable:	Father	Mother	Brothers	Sisters	Spouse	Children
Age (if living)	_____	_____	_____	_____	_____	_____
Health (G=Good, P=Poor)	_____	_____	_____	_____	_____	_____
Cancer	_____	_____	_____	_____	_____	_____
Diabetes	_____	_____	_____	_____	_____	_____
Heart Disease	_____	_____	_____	_____	_____	_____
High Blood Pressure	_____	_____	_____	_____	_____	_____
Stroke	_____	_____	_____	_____	_____	_____
Mental Illness	_____	_____	_____	_____	_____	_____
Asthma/Hay fever/Hives	_____	_____	_____	_____	_____	_____
Kidney Disease	_____	_____	_____	_____	_____	_____
Age (at death)	_____	_____	_____	_____	_____	_____
Cause of Death	_____	_____	_____	_____	_____	_____

9. Height: _____ **Weight:** Currently: _____ Past Maximum: _____ When? _____

10. Blood Pressure: What is your most recent blood pressure reading? _____/_____ When was this reading taken? _____

11. Childhood Illness (please circle any that you have had):

Scarlet Fever Diphtheria Rheumatic Fever Mumps Measles German Measles Chicken Pox

12. Hospitalizations and Surgeries:

Reason	When	Reason	When
_____		_____	
_____		_____	
_____		_____	

13. X-Rays/CAT Scans/MRI's/NMR's/Special Studies:

Reason	When	Reason	When
_____		_____	
_____		_____	
_____		_____	

14. Emotional (please circle any that you experience now and underline any that you have experienced in the past):

Mood Swings Nervousness/Anxiety Mental Tension Depression Disturbing Dreams

15. Energy and Immunity (please circle any that you experience now and underline any that you have experienced in the past):

Fatigue Slow Wound Healing Chronic Infections Chronic Fatigue Syndrome

16. Head, Eye, Ear, Nose, and Throat (please circle any that you experience now and underline any that you have experienced in the past):

Impaired Vision Eye Pain/Strain Glaucoma Tearing/Dryness Chronic Red Eyes

Impaired Hearing Ear Ringing Earaches Headaches/Migraines Sinus Problems

Nose Bleeds Frequent Sore Throats Teeth Grinding TMJ/Jaw Problems Hay Fever

17. Respiratory (please circle any that you experience now and underline any that you have experienced in the past):

Pneumonia Frequent Common Colds Difficulty Breathing Emphysema

Persistent Cough Pleurisy Asthma Tuberculosis

Shortness of Breath Other Respiratory Problems: _____

18. **Cardiovascular** (please circle any that you experience now and underline any that you have experienced in the past):

Heart Disease Chest Pain High Blood Pressure Palpitations/Fluttering

Stroke Heart Murmurs Rheumatic Fever Varicose Veins

19. Gastrointestinal (please circle any that you experience now and underline any that you have experienced in the past):

Ulcers Changes in Appetite Blood in stool Abdominal Pain Gas/Belching Heartburn Bloating

Constipation Diarrhea Nausea/Vomiting Gall Bladder Disease Hemorrhoids

Can't tolerate raw foods

20. Genito-Urinary Tract (please circle any that you experience now and underline any that you have experienced in the past):

Kidney Disease Painful Urination Frequent UTI Frequent Urination Heavy Flow

Kidney Stones Impaired Urination Blood in Urine Frequent Urination at Night

21. Female Reproductive/Breasts (please circle any that you experience now and underline any that you have experienced in the past):

Irregular Cycles Heavy Flow Light Flow Clots Dark brownish menses Very pale menses Mucousy menses

Painful Periods Bleeding Between Cycles Premenstrual Problems Abnormal Vaginal Discharge Vaginal itching

Menopausal Symptoms Difficulty Conceiving Breast Lumps/Tenderness Nipple Discharge

22. Menstrual/Birthing History:

1. Age of First Menses: _____ 2. # of Days Bleeding: _____ 3. Length of Entire Cycle (i.o.w day 1 to day 1): _____

4. Birth Control Type: _____ 5. # of Pregnancies: _____ 6. # of Miscarriages: _____

7. # of Abortions: _____ 8. # of Live Births: _____

23. Musculoskeletal (please circle any that you experience now and underline any that you have experienced in the past):

Neck/Shoulder Pain Muscle Spasms/Cramps Arm Pain Upper Back Pain Mid Back Pain

Low Back Pain Leg Pain Joint Pain (if so, where?): _____

24. Neurologic (please circle any that you experience now and underline any that you have experienced in the past):

Vertigo/Dizziness Paralysis Numbness/Tingling Loss of Balance Seizures/Epilepsy

25. Endocrine (please circle any that you experience now and underline any that you have experienced in the past):

Hypothyroid Hyperthyroid Hypoglycemia Diabetes Mellitus

26. Temperature (not what thermometer says, but how you FEEL)

Normal Tend to Warm Extreme HEAT Tend to Cold Extreme COLD Can't tolerate either extreme

Extreme Cold Hands/Feet (when rest of body normal temp)

If extreme, what other symptoms will you get if you get overheated or overly cold:

_____

Is there a time of day/night when you regularly feel a change in temperature?

_____

27. Thirst:

normal never thirsty always thirsty thirsty with no desire to drink

Prefer variable temperature liquids depending on weather Always prefer ice cold drinks Always prefer hot drinks

28. Fluid metabolism

Swelling (location/s): _____ changes with cycle

Sweat: normal feels excessive not enough not at all excessive odor greasy yellow

At these times or under these conditions: _____

29. Other (please circle any that you experience now and underline any that you have experienced in the past):

Anemia Cancer Rashes Eczema/Hives

29. **Lifestyle:**

a. Do you typically eat at least three meals per day? Y N If no, how many? _____

Do you consider them "balanced"? Y N Do you know what a balanced meal is? Y N

Are you aware of changes in your symptoms/energy/moods based on what you eat? Y N

Do you typically crave certain types of food? (i.e. salty/crunchy, sweet, fatty) Y N If yes, what type?_____

Do you enjoy cooking and/or eating healthy foods? Y N

Do you think you have, or have ever had, an eating disorder? Y N If yes, please explain:_____

_____

Are there foods for which you have sensitivities: If so, please list and include the symptoms you'll get when you eat them:

_____

_____

b. Exercise activities: _____ How many times per week?_____times

Do you enjoy exercise? Y N

c. Spiritual practice: _____

d. How many hours per night do you sleep? _____ Do you wake rested? Y N

Is it hard to fall asleep? Y N If yes, once you fall asleep, do you generally stay asleep? Y N

Is it hard to stay asleep? Y N If so, is there a typical time in which you usually wake? _____pm/am

Do you often feel tired throughout the day? Y N If so, is there a typical time in which this happens?_____pm/am

If so, is it associated with pre or post-eating? Y, pre Y, post N

e. Level of education completed: High School Bachelors Masters Doctorate Other

f. Occupation: _____ Employer: _____ Hours/Week: _____

Do you enjoy work? Y/N Why/Why not? _____

g. Nicotine/Alcohol/Caffeine Use: _____

h. Have you experienced any major traumas? Y N Explain: _____

_____

i. How many glasses of non-caffeinated, non-carbonated liquids do you drink per day? _____ How many sodas?_____

j. Television habits: _____ Reading habits: _____

k. Do you have a satisfying network of support and friends? Y N If not, do you see this as a problem? Y N

l. Interests and hobbies: _____