PACIFIC HEALING 32670 Highway 20, Suite 5 Fort Bragg, CA (707) 969-7148

Acupuncture

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Adult Health History Intake

Patient Name: _____

Please describe the reason for your visit today. (Chief complaint)

_____

_____

How long have you had this problem?_____

What does it feel like when it hurts?_____

Does the problem occur at a specific time of day?_____

Is it getting better, worse, or unchanged, what makes it better or worse?_____

What other associated problems have you been having?_____

Have you been, treated for this problem by any other health professionals? If so, where and by whom?

_____

Has it been effective? _____

What was your diagnosis:_____

Do you have any chronic infectious diseases or chronic illness? (for example: Hep B, Hep C, HIV, Aids, etc) Y N

If so please explain: _____

Are you taking any medications or herbal supplements? Y N If so, which ones? (please include dosage info if known)_____

Have you ever been hospitalized or had any surgical procedures? If so please list the reason and the date:

_____

Have you ever had any X-rays, CAT Scans, MRI's/NMR's/Special Studies? If so, please list the reason and date:

_____

Have you ever experienced any major traumas or injuries (mentally or physically in nature) ? If so, please list with dates:_____

Do you, or have any of your family members suffered from: (Please list relationship to you)

Alcoholism_____	Arteriosclerosis_____	Heart Disease_____
Allergies (list)	Asthma_____	High Blood Pressure_____
_____	Cancer_____	Seizures_____
_____	Diabetes_____	Stroke_____
_____	Mental Illness_____	

Which of the following is part of your lifestyle? How frequently do you engage in it?

Alcohol_____	Nicotine_____	Exercise_____
Coffee_____	Recreational Drug Use_____	Meditation_____
Drink cola_____	How much water in a day_____	

How many hours do you sleep? _____ How many hours do you work in a week?_____ Enjoy work? Y N
Please indicate typical diet: (circle all that apply)
Gluten Free Dairy Free Vegetarian Vegan Raw Only Meat Eater: Bird Fish Red Meat

WOMEN ONLY

Indicate now or in the past where applicable:

Are you or could you be pregnant? Y N # of pregnancies? ____ Births____ Abortions____ Miscarriages_____
Any difficulties in conceiving? Y N Did you seek fertility help, and what type_____
What form of birth control do you use? _____ Do you do self breast self exams? Y N
Do you have regular PAP smears?_____ How often?_____ Any history of abnormal PAPs?_____
Age of first menses?_____ Age of menopause, if applicable_____ Menopause symptoms Y N
Do you bleed between periods? Y N Do you bleed after intercourse? Y N
Do you experience any pain during or after intercourse? Y N
Have you ever had any gynecological surgeries or any abnormal findings on any tests? _____
Do you have any vaginal discharge? (this includes ovulation) Y N If so, how often?_____
How much?_____ What color?_____ Odor?_____
Do you experience nipple discharge? Y N Breast lumps or pain? Y N
Are your periods uncomfortable or painful, either emotionally or physically? Y N Endometriosis Y N
Are your periods? Short (less than 28 days) _____ Long (28+days)_____ Varied_____ Regular_____
Painful? Y N If so, Before_____ During_____ After_____ Where?_____
Do you bleed heavily? ____ Lightly? ____ Very little? ____
Do you have clots? Y N Early in the cycle? ____ or throughout? ____
Relative to the blood that comes from a wound, is your menstrual blood:
The same color _____ more pale_____ purple_____ more red_____ more brown_____
How many days do you bleed?_____
Do you have any of the following Pre-Menstrual Symptoms? (emotions are not judged in Chinese Medicine, they are neither good nor bad. They are, however, an important diagnostic tool. Please answer honestly.
Irritability_____ Depression_____ Crying_____ Rage_____ Nausea_____
Cravings, and if so for what?_____ Breast Tenderness_____
Any other symptoms around the time of your period?_____
Are you experiencing any low or high sexual desire?_____ Do you have any concerns surrounding this?_____

Men Only

Do you experience any of the following now or in the past, indicate which:
Reduced Libido_____ Excessive Libido_____ Impotence_____
Premature Ejaculation_____ Discharge_____ Genital/Testicular pain or swelling_____
Prostrate Problems?_____ Hernias_____
Testicular mass_____
Any other concerns?_____

I have provided correct and complete information to the best of my knowledge.

Signature: _____ Date: _____