BOULDER FAMILY ACUPUNCTURE 2955 Valmont St, Ste. 100, Boulder, CO 80301 (303) 859-7556

Patient Health History

Name: _____ Date: _____

Date of Birth: _____ Age: _____ Gender: _____ Marital status: _____

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. Has your case been referred to an attorney? ____Y ____N

3. Please identify the health concerns that have brought you to our clinic in order of importance below:

Condition	Past Treatment
a. _____	_____
How does this condition affect you? _____	
b. _____	_____
How does this condition affect you? _____	
c. _____	_____
How does this condition affect you? _____	
d. _____	_____
How does this condition affect you? _____	

4. If applicable, please list any foods, drugs, or medications you are hypersensitive or allergic to (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 infectious diseases? ____ Y ____ N If yes, please identify: _____

7. 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	_____	_____	_____	_____	_____	_____

8. Height: _____ Weight: Currently: _____

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

10. Illness (please check any that you have had):

____ Scarlet Fever ____ Diphtheria ____ Rheumatic Fever ____ Mumps ____ Measles ____ Chicken Pox

____ Cancer (_____) ____ Kidney disease ____ Liver Disease ____ Diabetes ____ Heart Disease

____ High Blood Pressure ____ Stroke ____ Mental Illness ____ Addiction ____ Asthma

____ Allergies – (_____) ____ Autoimmune Disease – (_____)

11. Hospitalizations and Surgeries:

Reason	When	Reason	When
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

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

Reason	When	Reason	When
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

13. Put a check mark by the symptoms that pertain to you.

____Cold Hands/Feet
____ Fatigue
____Feverish In The Afternoon Or Flushes
____Heat Sensations In Hands, Feet, Chest
____Night Sweats
____ Catch Colds Easily
____ Sweat Easily
____ Dizziness
____ See Floating Black Spots
____Palpitations
____Sore On Tip Of Tongue
____ Restlessness
____ Anxiety
____ Chest Pain Radiating To Shoulder
____ Insomnia
____ Cough
____ Sinus Congestion
____ Dry Mouth, Throat, Nose Or Skin
____ Allergies
____Chills Alternating With Fever
____Stiff Neck/Shoulders
____ Sore Throat
____ Difficult Breathing
____ Low Appetite
____ Loose Stools
____ Constipation
____ Abdominal Bloating And/Or Gas After Eating
____ Feeling Tired After Eating
____ Prolapsed Organs (Previously Diagnosed)
____Bruise Easily
____General Feeling Of Heaviness In Body
____Mental Heaviness, Sluggishness Or Fogginess
____Swollen Hands/Feet
____ Burning Sensation After Eating
____ Large Appetite
____ Bad Breath
____ Mouth (Canker) Sores
____ Bleeding, Swollen Painful Gums
____ Heartburn/Belching
____ Stomach Pain
____Vomiting
____Diarrhea Alternating With Constipation
____Tight Feeling In Chest
____Bitter Taste In Mouth
____ Blood Shot Eyes/Dry Eyes
____ Anger Easily
____ Irritability
____ Skin Rashes
____ Headache - Location: _____
____ Numbness Of Hands And Feet
____Muscle Spasms, Twitching, Cramping
____ Seizures/Convulsions
____ Sore, Cold Or Weak Knees
____Low Back Pain
____ Frequent Urination
____ Get Up More Than Once A Night To Urinate
____ Lack Of Bladder Control
____ Memory Problems
____Hair Loss
____Ringing In Ears
____Urine Is:
    ____ Normal Color
    ____ Clear
    ____Dark Yellow
    ____Reddish
    ____Cloudy
    ____ Scanty
    ____ Has Odor
    ____ Burning
    ____ Painful
    ____ Difficult
    ____ Urgent
____Libido (Sex Drive) Is:
    ____Normal
    ____ Low
    ____High

14. Women only

Please answer each question or check the appropriate response.

1. Are you pregnant now? ____Yes ____No If so, how far along? _____ weeks
2. Number of Children _____
3. Number of pregnancies _____
4. Age of first period _____
5. Age of menopause (if applicable) _____
6. Is your menses regular? ____ Yes ____No

Average number of days of flow _____
Average number of days of cycle _____
The flow is: ____ Normal ____Heavy ____Light
The color is:

____Normal ____Dark ____ Purple ____Light Brown ____Brown ____Other_____

Do you have the following menstruation related signs/symptoms?

____Blood clots Approximate size _____ Color _____
____Cramps
____Nausea
____Breast distension

____PMS
____Bleeding between periods
____Heavy vaginal discharge between periods
Color: _____

Other information that you think I should know about:
_____
_____
_____

15. Men Only

Please put a check mark by the symptoms that pertain to you.
____ Feeling of coldness or numbness in external genitalia.
____Pain or swelling of testicles
____Premature ejaculation
____Impotence/erectile dysfunction

Other information that you think I should know about:
_____
_____
_____

16. Lifestyle:

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

b. Typical day's diet: _____

_____

c. Exercise routine: _____

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

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

Do you enjoy work? ____ Y ____N Why/Why not? _____

f. Nicotine/Alcohol/Caffeine Use: _____

g. Have you experienced any major traumas? ____Y ____ N Explain: _____

_____

_____

h. How many ounces of non-caffeinated, non-carbonated beverages do you drink per day? _____

i. Interests and hobbies: _____