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New Leaf Acupuncture Patient Health History

Name: ____ Date of Birth:__________ M F Date: __________
(first) (middle) (last)

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. Please identify the health concerns that have brought you to the Hillsboro New Leaf Wellness 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? ____

2. When and where did you last receive health care? ______________________________________

For what reason? ____

3. Has your case been referred to an attorney? Y N

4. Please list any medications (prescribed and over-the-counter), vitamins, and supplements you are currently taking on the Patient Information sheet.

In addition, list any foods, drugs, or medications you are hypersensitive or allergic to (please include reaction).

5. Do you have any reason to believe you may be pregnant? Y N If so, how far along are you? ____________

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

7. **Height:** ________ **Weight:** Currently: ________ Past Maximum: ________ When? ______________

8. **Blood Pressure:** What is your most recent blood pressure reading? ______/______ When was this reading taken? ________

Name: ______________________ DOB: ______________ Date: ______________

9. **Family History:**	Father	Mother	Brothers	Sisters	Spouse	Children
Check those applicable:						
Age (if living)	____	____	____	____	____	____
Overall Health	____	____	____	____	____	____
Cancer	____	____	____	____	____	____
Diabetes	____	____	____	____	____	____
Heart Disease	____	____	____	____	____	____
High Blood Pressure	____	____	____	____	____	____
Stroke	____	____	____	____	____	____
Mental Illness	____	____	____	____	____	____
Asthma/Hay fever/Hives	____	____	____	____	____	____
Kidney Disease	____	____	____	____	____	____
Age (at death)	____	____	____	____	____	____
Cause of Death	____	____	____	____	____	____

10. **Childhood Illness and Diseases** Please circle childhood **illnesse**s that you have had:

Scarlet Fever Diphtheria Rheumatic Fever Mumps Measles German Measles Chicken Pox

Please circle **immunizations** that you have had:

Polio Tetanus Rubella/Mumps/Rubella Pertussis Diphtheria Hib Hepatitis B

11. **Chronic Diseases & Conditions (please include any autoimmune or metabolic problems):** ______________________

____

12. **Health History:** **Hospitalizations, surgeries:** **Past injuries:**

When Reason When Incident

______________________ ______________________

______________________ ______________________

______________________ ______________________

X-Rays/CAT Scans/MRI's/NMR's/Special Studies: **Sports or intense physical activities done:**

When Reason

______________________ ______________________

______________________ ______________________

Name: ____ DOB: ________________________ Date:__________________

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

Mood Swings Nervousness Mental Tension Feeling Down Stress

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

Fatigue Slow Wound Healing Easily Bruise Chronic Infections Chronic Fatigue Syndrome

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

Impaired Vision Eye Pain/Strain Glaucoma Glasses/Contacts Tearing/Dryness

Impaired Hearing Ear Ringing Earaches Headaches Sinus Problems

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

18. **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: ____

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

Heart Disease Chest Pain Swelling of Ankles High Blood Pressure

Palpitations/Fluttering Stroke Heart Murmurs Rheumatic Fever Varicose Veins

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

Ulcers Changes in Appetite Nausea/Vomiting Epigastric Pain Passing Gas Heartburn

Belching Gall Bladder Disease Liver Disease Hepatitis B or C Hemorrhoids Abdominal Pain

21. **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 Hesitant Urination Blood in Urine Frequent Urination at Night

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

Irregular Cycles Breast Lumps/Tenderness Nipple Discharge Heavy Flow

Vaginal Discharge Premenstrual Problems Clotting Bleeding Between Cycles

Menopausal Symptoms Difficulty Conceiving Painful Periods

23. **Menstrual/Birthing History:**

Age of First Menses: ____ # of Days of Menses: ____ Length of Cycle: ____ Birth Control Used: ____

# of Pregnancies: ____ # of Miscarriages: ____ /Abortions: ____ # of Live Births: ____ Age at menopause ____

Name: ____ DOB: _____________________ Date:________________

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

Sexual Difficulties   Prostrate Problems   Testicular Pain/Swelling   Penile Discharge

25. **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?): ______________________________________

26. **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

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

Hypothyroid   Hypoglycemia   Hyperthyroid   Diabetes Mellitus   Night Sweats   Feeling Hot or Cold

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

Anemia   Cancer   Rashes   Eczema/Hives   Cold Hands/Feet

Lack of focus/mental clarity   Forgetfulness

Is there anything else we should know? ____

____

29. **Lifestyle:**

- Typical meals/foods:____ # of meals/day_____
- Dietary restrictions (food sensitivity, vegetarian, etc): ____
- Exercise routine/activity level: ____
- How many hours per night do you sleep? ________   Do you wake rested?   Y   N
- Level of education completed: High School   Bachelors   Masters   Doctorate   Other
- Occupation: ______________________________   Employer: _____________________   Hours/Week: _______
- Your general outlook on life: ____
- Please list any religious or philosophical restrictions to treatment:________________________________
- Nicotine/Alcohol/Drug or Caffeine Use:____
- How much water do you drink per day? _____   Other drinks (what and how much): ____________________
- Have you experienced any major traumas?   Y   N   Explain: ______________________________________
- Television habits: _____________________________   Reading habits: _______________________________
- Interests and hobbies: ____