

Health History Form

First Name:	Last Name:	Date:
Address:		Email:
Home #:	Work #:	Referred by:
Date of Birth:	Gender:	Occupation:
Emergency Contact:		Contact #:

Chief Complaint:	
(Briefly identify the main health problem/condition and how long you have experienced this for)	

Past and Present Medical Conditions: (Please include dates)	
<input type="checkbox"/> Allergies <input type="checkbox"/> A s t h m a <input type="checkbox"/> Anemia <input type="checkbox"/> Arthritis <input type="checkbox"/> Cancer <input type="checkbox"/> CFS/Fibromyalgia <input type="checkbox"/> Depression/Mental Condition <input type="checkbox"/> Diabetes <input type="checkbox"/> Digestive Disorder <input type="checkbox"/> Eating Disorder <input type="checkbox"/> Epilepsy/Seizures	<input type="checkbox"/> Heart Disease/Stroke <input type="checkbox"/> Hemophilia <input type="checkbox"/> Hepatitis/Liver Disease <input type="checkbox"/> High/Low Blood Pressure <input type="checkbox"/> HIV Positive <input type="checkbox"/> Kidney Disease <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Skin Disease <input type="checkbox"/> Thyroid Disease <input type="checkbox"/> Other:
<p>Please list any injuries and surgeries you have experienced with dates:</p> 	

Current Medication, Supplement or Herbs: (Please indicate the condition that it treats)	

Family Health History: (Briefly list major health issues)	
Father: Mother: Other:	

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Lifestyle

Work hours per week: _____ Sleep hours per night: _____

Special diet and food sensitivity: _____

Exercise type and frequency: _____

Caffeine/Smoke/Alcohol/Substance use and frequency: _____

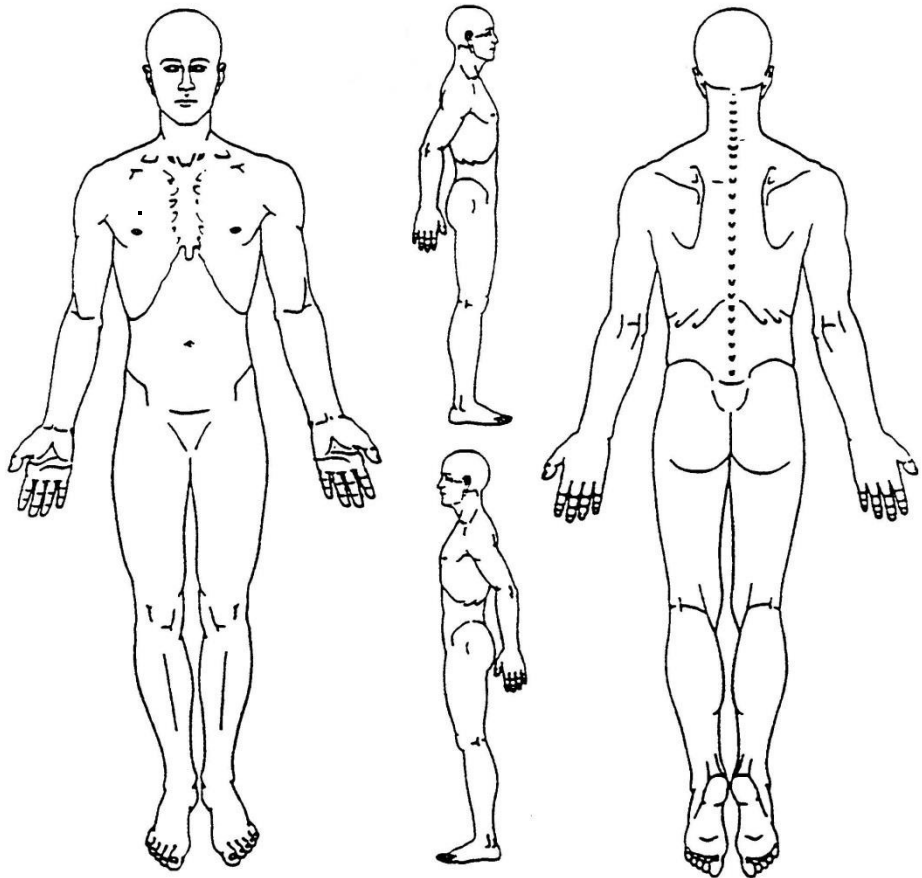
Energy and Stress Levels: (Please circle)

Energy levels: High Average Low Extremely Low

Stress levels: Low Average High Extremely High

Pain Chart

Where on your body do you feel pain?



<u>General Symptoms</u>	
<input type="checkbox"/> Fatigue <input type="checkbox"/> Poor or shallow sleep <input type="checkbox"/> Body heaviness <input type="checkbox"/> Body feels more cold (chills) <input type="checkbox"/> Body feels warmer (fever) <input type="checkbox"/> Poor circulation	<input type="checkbox"/> Prefer cold drinks <input type="checkbox"/> Prefer warm drinks <input type="checkbox"/> Cold hands <input type="checkbox"/> Cold feet <input type="checkbox"/> Water retention or swelling <input type="checkbox"/> Recent weight gain or loss <input type="checkbox"/> Sweat easily
<u>Heart Symptoms</u>	
<input type="checkbox"/> Insomnia <input type="checkbox"/> Dream-disturbed sleep <input type="checkbox"/> Anxiety <input type="checkbox"/> Palpitations <input type="checkbox"/> Chest pains <input type="checkbox"/> <u>Speech problem:</u>	<input type="checkbox"/> Restlessness <input type="checkbox"/> Hyperactivity <input type="checkbox"/> Being overly talkative <input type="checkbox"/> Inability to concentrate <input type="checkbox"/> Poor memory <input type="checkbox"/> Startled easily <input type="checkbox"/> Faint easily
<u>Liver Symptoms</u>	
<input type="checkbox"/> Depression <input type="checkbox"/> Moody <input type="checkbox"/> Irritability <input type="checkbox"/> Indecisive <input type="checkbox"/> Sighing <input type="checkbox"/> Nervousness <input type="checkbox"/> Distension pain in the chest or ribs <input type="checkbox"/> Feeling of lump in the throat <input type="checkbox"/> Numbness of the limbs <input type="checkbox"/> <u>Eye problem:</u>	<input type="checkbox"/> Emotional triggered symptom (eg. headache, poor digestion, insomnia) <input type="checkbox"/> Repressed emotions <input type="checkbox"/> Easily angered <input type="checkbox"/> Dizziness or vertigo <input type="checkbox"/> Trembling or shaky hands <input type="checkbox"/> Tics or twitching <input type="checkbox"/> Muscle cramp or spasm <input type="checkbox"/> Tight and stiff muscles <input type="checkbox"/> Severe migraines and headaches
<u>Spleen/Stomach Symptoms</u>	
<input type="checkbox"/> Improper eating habits <input type="checkbox"/> Poor appetite <input type="checkbox"/> Bloating and gas <input type="checkbox"/> Belching and hiccup <input type="checkbox"/> Abdominal distension and pain <input type="checkbox"/> Loose stool <input type="checkbox"/> Diarrhea <input type="checkbox"/> Constipation <input type="checkbox"/> <u>Rectal problem:</u>	<input type="checkbox"/> Muscle weakness <input type="checkbox"/> Bleed or bruise easily <input type="checkbox"/> Worry a lot <input type="checkbox"/> Obsessive thoughts <input type="checkbox"/> Nausea and vomiting <input type="checkbox"/> Acid reflux <input type="checkbox"/> Bad breath <input type="checkbox"/> <u>Mouth/gum problem:</u> <input type="checkbox"/> <u>Cravings:</u>

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Lung Symptoms

- | | |
|--|---|
| <input type="checkbox"/> Cough
<input type="checkbox"/> Wheezing
<input type="checkbox"/> Shortness of breath
<input type="checkbox"/> Difficulty breathing
<input type="checkbox"/> Chest tightness
<input type="checkbox"/> <u>Nose and throat problem:</u> | <input type="checkbox"/> Repeated sore throat
<input type="checkbox"/> Swollen glands
<input type="checkbox"/> Sadness or grief
<input type="checkbox"/> Cry easily
<input type="checkbox"/> Foggy or clouded mind
<input type="checkbox"/> <u>Skin problem:</u> |
|--|---|

Kidney Symptoms

- | | |
|---|---|
| <input type="checkbox"/> Sore/weak lower back
<input type="checkbox"/> Sore/weak knee joint
<input type="checkbox"/> Low sex drive
<input type="checkbox"/> Overwork or intensive workout
<input type="checkbox"/> Night sweat
<input type="checkbox"/> Teeth or hair loss
<input type="checkbox"/> <u>Ear problem:</u> | <input type="checkbox"/> Exhaustion or afternoon crash
<input type="checkbox"/> Fears
<input type="checkbox"/> Addictive patterns
<input type="checkbox"/> Abuse survivor
<input type="checkbox"/> Lack motivation or drive
<input type="checkbox"/> Forgetfulness
<input type="checkbox"/> <u>Urination problem:</u> |
|---|---|

Gynecology

- | | |
|--|--|
| <input type="checkbox"/> Menopausal
<input type="checkbox"/> Vaginal discharge
<input type="checkbox"/> Breast lumps
<input type="checkbox"/> Currently pregnant
of weeks pregnant:
of past pregnancies:
of live births:
Delivery due date: | <input type="checkbox"/> Irregular menstruation
<input type="checkbox"/> Severe menstrual cramps
Date of last period:
Days in cycle:
Length of period:
Menstrual flow, colour, clots:
Premenstrual Symptoms: |
|--|--|

Consent Given for Assessments:
Consent Given for Treatment:

Requests/Comments/Notes:

Inquiring	<u>Pattern</u>
<p>Chief complaint and duration:</p> <p>History of chief complaint: (onset, nature and location of disease, accompanying symptoms, relieving and aggravating factors, medical tests and diagnosis, other treatments and treatment results)</p> <p>General Information: (10 questions, lifestyle, energy, stress, emotion, pain)</p>	

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Vitality: (Spirit, face, hair, nails, skin, body shape, voice, smell)
Tongue: (body shape, colour, movement, coating thickness, colour, moisture, location, and sublingual veins)
Pulse: (rate, strength, quality)

Practitioner:	Treatment Plan

TCM Disease Diagnosis:		
TCM Syndrome Differentiation	Treatment Principles	Points / Modalities
Primary Diagnosis:		
Secondary Diagnosis:		
		# of needles in: # of needles out:

Treatment Results and Recommendations: