

## PATIENT HEALTH HISTORY

Name: \_\_\_\_\_

(first) (MI) (last)  
 DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_\_ Gender: M / F Today's date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_

State: \_\_\_\_\_ ZIP: \_\_\_\_\_ Marital Status: S / M / D / W / Partnered

Email (we do not share your email address with anyone; it is used to send you office information only) :

Phone: \_\_\_\_\_ (day) \_\_\_\_\_ (eve) \_\_\_\_\_ (cell)

1. What conditions are you seeking help with today? (list in order of importance)

Condition

Effect on your life

a. \_\_\_\_\_

a. \_\_\_\_\_

b. \_\_\_\_\_

b. \_\_\_\_\_

c. \_\_\_\_\_

c. \_\_\_\_\_

d. \_\_\_\_\_

d. \_\_\_\_\_

2. Have you received acupuncture or taken Chinese herbal medicine before? Y/N

If yes, approximate date of last treatment: \_\_\_\_\_

What was the purpose of the visit/herb formula? \_\_\_\_\_

3. **Medications/Supplements/Vitamins** (list prescriptions, OTC medicines, & natural substances you are currently taking)

Drug/Substance	Dose/Frequency	Reason	Drug/Substance	Dose/Frequency	Reason
1.			4.		
2.			5.		
3.			6.		

4. **Allergies** (list allergies or sensitivities to any drug or natural substance, including when the allergy started)

Drug/Substance	Reaction	How long?	Drug/Substance	Reaction	How long?
1.			4.		
2.			5.		
3.			6.		

5. **Hospitalizations/Operations**

Date	Reason for hospitalization/procedure	Outcome
1.		
2.		

**6. Family History** (check those that apply):

	Age (or age at death)	Health (G = good) (P = poor)	Cancer	Diabetes	Heart Dz	Mental Illness	Stroke	Other
Grandparent								
Father								
Mother								
Siblings								
Spouse								
Children								

7. Which childhood illnesses have you had?

- chicken pox       diphtheria     measles     mumps     recurrent ear infections

8. What was your most recent blood pressure reading? \_\_\_\_/\_\_\_\_      When was this taken? \_\_\_\_/\_\_\_\_/\_\_\_\_

9. What was the date of your last physical exam? \_\_\_\_/\_\_\_\_/\_\_\_\_

Were there any significant findings? \_\_\_\_\_

10. What are the names of your current medical doctors and/or healthcare providers?

Physician/Other Provider	Address	Phone # (if known)

**11. Lifestyle:**

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

b. Exercise routine: \_\_\_\_\_

c. How many hours per night do you sleep? \_\_\_\_\_      Do you wake rested? Y/N

d. Level of education completed: High School/Bachelors/Masters/Doctorate/Other \_\_\_\_\_

e. Occupation: \_\_\_\_\_      Employer: \_\_\_\_\_

Hours/Week: \_\_\_\_\_      Do you enjoy work? Y/N

Why/Why not? \_\_\_\_\_

f. Do you currently (or have you in the past) consumed any of the following?

Substance	Y/N/Past	Amount	How Often?	How Long?
Alcohol				
Caffeine				
Cigarettes				
Drugs				

12. Please indicate which of the following conditions you have had:

**Cardiovascular**

- chest pain
- cold hands/feet
- heart disease
- heart murmur
- high blood pressure
- high cholesterol
- palpitations
- stroke
- varicose veins
- other: \_\_\_\_\_

**Dermatologic**

- acne
- age spots
- allergic dermatitis
- carcinoma
- eczema
- hives
- itching
- psoriasis
- rash
- rosacea
- sensitive skin
- shingles
- other: \_\_\_\_\_

**Ear/Eye/Nose/Throat**

- ear ringing
- frequent ear infection
- loss of hearing
- glasses/contacts
- glaucoma
- impaired vision
- dry eyes/tearing
- nosebleed
- sinus problems
- sneezing/runny nose
- dry mouth
- sore throat
- grinding teeth/TMJ
- other: \_\_\_\_\_

**Emotional**

- abuse
- addiction
- anxiety
- depression
- frustration
- mental tension
- mood disorder
- overwhelm
- stress
- other: \_\_\_\_\_

**Endocrine**

- adrenal fatigue
- diabetes
- hyperthyroid
- hypothyroid
- hypoglycemia
- hormonal imbalance
- other: \_\_\_\_\_

**Energy/Immunity**

- allergies/hayfever
- anemia/easy bruising
- auto-immune disorder
- cancer
- Chronic Fatigue
- easily tired
- exotic disease
- fibromyalgia
- high fever
- infectious disease
- slow wound healing
- other: \_\_\_\_\_

**Gastro-Intestinal**

- abdominal pain
- belching
- change in appetite
- constipation
- diarrhea
- gallstones
- gas/bloating
- heartburn/acid reflux
- hemorrhoids
- liver disease
- ulcer
- other: \_\_\_\_\_

**Genito-Urinary**

- bloody urine
- frequent urination
- incontinence
- kidney infection
- kidney stones
- UTI
- other: \_\_\_\_\_

**Musculo-Skeletal**

- back pain
- broken bone
- injury/trauma
- joint pain
- muscle cramps
- neck/shoulder tension
- weakness

**Neurologic**

- dizziness
- headache/migraine
- head injury
- numbness/tingling
- paralysis
- seizures

**Respiratory**

- asthma
- bronchitis
- emphysema/COPD
- frequent cold/flu
- persistent cough
- pneumonia
- shortness of breath
- other: \_\_\_\_\_

**Reproductive (men)**

- hernia
- impotence
- low libido
- low motility/sperm count
- penile discharge
- prostatitis
- testicle pain/swelling
- other: \_\_\_\_\_

**Reproductive (women)**

**Breasts:**

- discharge
- lumps
- tenderness

**Menses:**

- bleeding b/t cycles
- clotting
- endometriosis
- heavy menses
- scanty menses
- irregular cycles
- ovarian cysts
- PMS

**Other:**

- hot flashes
- infertility/difficulty conceiving
- mood swings
- low libido
- night sweats
- oral contraceptive use
- vaginal discharge
- vaginal dryness

13. Who may we contact in case of emergency?

Name: _____	Relationship: _____
Address: _____	Phone #: _____

14. How did you hear about us?

- personal referral     
 medical referral     
 newspaper     
 yellow pages  
 other: \_\_\_\_\_

If personal referral, who may we thank for referring you? \_\_\_\_\_

### CONFIDENTIALITY STATEMENT & FINANCIAL AGREEMENT

*By signing below I indicate that I have read and agree to the following:*

- All information contained herein is, to the best of my knowledge, a complete and accurate statement of my health history.
- All information contained herein is confidential in nature and will be viewed only by staff and employees of Essential Being Health or its third-party designates and will not be released without my written consent.
- Should I require my records be released to another party, I must make my request in writing and sign a formal consent form. I will be charged a fee of \$1 per page of copied material.
- I understand that payment is due in full at time of service. It is my sole responsibility to make payments for services rendered. A \$25 fee will be charged for returned checks and must be paid, along with full amount due, within 15 days of notice from our office. Accounts 30 days past due are subject to collection.
- I understand that I must cancel any appointment with this office no less than 24 hours in advance to avoid incurring a cancellation fee. Appointments cancelled less than 12 hours in advance will be charged the full amount of missed appointment. Payment must be made within 15 days of missed appointment.
- I acknowledge that I have received the NOTICE OF PRIVACY PRACTICES of this practice, which outlines how my health records are shared.

<b>PATIENT NAME (please print)</b> _____
<b>PATIENT SIGNATURE</b> <b>X</b> _____
<b>Relationship to Patient (if acting as patient representative)</b> _____ <b>DATE:</b> _____

**OFFICE USE ONLY:**

<b>SIGNATURE:</b> _____ (designated office staff or practitioner)	<b>DATE:</b> _____
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