# Health History

ADVANCED HEALING
ACUPUNCTURE - MASSAGE - NUTRITION
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Last Name: _____ First Name: _____ DOB:_____ /_____ /_____(m/d/y) Age:_____

**What is your Chief Complaint?**_____Date (or year) of onset:_____

| | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| Pain Level at its worst: | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| Pain Level at its best: | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| Pain Level today: | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |

Previous Treatments for this condition_____

Other Health Concerns: _____

_____

Please list past major surgeries, illnesses, and injuries _____

_____

Please list any significant family health history (cancer, diabetes, heart disease, etc.) _____

_____

Please list any current medications or over the counter drugs/supplements_____

_____

_____

How would you describe your diet?_____

Do you have any allergies? □Yes □No If so, please list_____

Are you pregnant? □Yes □No Do you think you may be pregnant? □Yes □No

Do you have a pacemaker? □Yes □No Do you have a bleeding disorder? □Yes □No

Have you experienced or are you currently experiencing any of the following conditions? (Please check all that apply)

| | | | | | |
|---|---|---|---|---|---|
| □Cancer | □Diabetes | □Hepatitis | □HIV/AIDS | □High Blood Pressure | □Heart Disease |
| □Thyroid Disease | □Asthma | □Vein Condition | □Stroke | □Nervous Disorder | □Low Immunity |

How much water do you drink per day? _____ Caffeine? _____ Alcohol?_____Tobacco?_____

Do you exercise? How often and what type?_____

**Check any of the following that you regularly experience:**

| | | | | |
|---|---|---|---|---|
| □Palpitations | □Nausea | □Difficulty falling asleep | □Night Sweats | □Ear/Eye/Nose/Throat Pain |
| □"Anxiety" | □Digestive Pain | □Difficulty staying asleep | □Hot flashes | □E/E/N/T Dryness |
| □Edema | □Tendency to constipation | □Difficulty waking | □Gets cold easily | □E/E/N/T Congestion |
| □Gas | □Tendency toward diarrhea | □Difficult to concentrate | □Overheats easily | □Ear Ringing |
| □Heartburn | □Frequent Urination | □Lack of thirst | □Sweats easily | □Skin Dryness |
| □Bloating | □Difficult/urgent urination | □Strong thirst | □Cold hands/feet | □Skin Itching |
| □Irritability | □Painful Urination | □Memory problems | □Other skin condition_____ | |

**Menses**: Age began:_____ Cycle length:_____days Flow length:_____days

Symptoms before period?_____ During?_____ After?_____

Birth Control? What type?_____ Menopause or Perimenopause?_____ Symptoms_____