Health History

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

Chief Complaint (choose one)_____Date (or year) of onset:_____

Pain Level at it's worst:	0	1	2	3	4	5	6	7	8	9	10
Pain Level at it's 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 legnth:_____days Flow length:_____days

Symptoms before period?_____ During?_____ After?_____

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