Confidential Health History

Name			**Date**
Address			**Height**
City	State	Zip	**Weight**
Phone (Cell)	(H/W)	Occupation	**Age**
E-mail		Marital Status	BP
Referred By			Bodyfat%
Family Physician			Date of birth
Insurance Carrier	Policy #		Case #
In case of Emergency			

Main problems you would like help with and how long you have experienced each symptom	**(physician use)** **TONGUE** **PULSE** **DIAGNOSIS** **Tx Principal**
Have you been given a **Western Diagnosis** for this problem? If so, what?	**Prescription** Points
What **types of treatments** have you tried?	**Guiding Formula**

Medicines taken within the last month (including vitamins, herbs, etc)

_____
_____
_____
_____
_____
_____

Would you like help in reducing or eliminating the medications you are taking?_____

Previous Illnesses (include dates)

Significant Disorders

Cancer	Diabetes	Thyroid Disease	Seizures
HIV/Aids	Rheumatic Fever	Viral Disease	Hepatitis
High BP	Heart disease	Other	

Surgeries (please include cosmetic)_____
_____
_____
_____
_____

Significant trauma_____
_____

Birth History (unusual circumstances)_____

Other relevant medical information_____
_____
_____
_____

Daily Health Influences

Daily Diet

How Healthy is your diet? (not) 1 2 3 4 5 6 7 8 9 10 (great)
How many meals/snack per day 1 2 3 4 5 6 7 8 9 10

How much water do your drink per day? _____ (2 quarts is recommended)
Exercise _____

Allergies_____
_____
_____

Habits (include numbers per day) *Confidential*

Cigarettes -	Coffee -	Sodas -	Snacks -	Other -
Alcohol -	Tea -	Drugs -	Salts -	

Occupational / Environmental Stresses (chemical, physical, mental) _____

Hobbies/Activities you do at least once per week_____

Please continue with the next two pages for internal medicine

General Health Imbalances (please circle any that apply)

Poor appetite Cravings Weakness Insomnia Night Sweats Cold hands or feet

Fatigue Bleed Easily Bruising Aversion to Wind Get Colds Often Chills Fever

Sweating very easily Poor Coordination Tremors Vertigo Unusual Taste in Mouth

Thirst Lack of thirst Preference for Hot / Cold Drinks Sensitivity to Sound Prolapse

Recent Changes in Finger/Toenail Breaking/Discoloration/Growth Inability to wake in morning

Other _____

Skin and Hair

Rashes Eczema Ulcerations Acne Purpura Hives Itching Dandruff Dry Skin

Change in Head Hair- Drying / Cracking / Unusual loss/ Other Body Hair Changes

Malar Flush Pale Skin Other _____

Head, Eyes, Ears, Nose and Throat

Eye- Strain / Pain / Dryness / Spots Color Blindness Cataracts Change in Vision Night Blind

Teeth- Pain / Loss / Sensitivity / Grinding Gums- Bleeding / Sores Lips- Dry/Cracked

Throat- Dry / Sore Jaw Clicking Concussions Dizziness Nose Bleeding Head Heaviness

Ringing in Ears Earaches Mucus / Secretions Hearing Loss Sensitivity to Sound

Headaches- Location/Times _____ Facial Pain- Location_____

Sinus Problems Other _____

Cardiovascular

High Blood Pressure Dizziness Blood Clotting Low Blood Pressure Fainting Phlebitis

Chest Pain/Distention/Heaviness Difficulty in Breathing Irregular Heartbeat Heart Palpitations

Swelling of Hands or Feet Other _____

Respiratory

Cough Pneumonia Coughing of Phlegm- Time/Color/Thickness _____

Coughing of Blood Asthma/Difficulty in Breathing Bronchitis Chest Tightness Nose Dry/Itchy

Inability to Take a Deep Breath Other _____

Gastrointestinal

Constipation Diarrhea Loose Stool Nausea Vomiting Gas Belching Bad Breath

Pain/Cramping/Sensitivity Bloody Stools Black Stools Rectal Pain Acid Reflux Hemorrhoids

Daily Bowel Movements- Frequency/Form _____

Abdominal Fullness Laxative Use Food in Stool Other _____

Genito-Urinary

Pain During Urination Inability to Hold Urine Waking at Night to Urinate Frequent Urination

Kidney Stones Blood in Urine Venereal Disease _____ Impotence

Sexual Dysfunction (Please Describe) _____

Sexual drive (loss) 1 2 3 4 5 6 7 8 9 10 (too high) Other _____

Pregnancy and Gynecology * Women only*

Age of Onset of Menses _____ Days in Cycle (28?)_____ Days Bleeding _____ Last Period_____

Qualities of Menses- Thick / Thin / Clots / _____ Color of Blood- Bright / Normal / Dark / _____

Vaginal Discharge _____Number of Pregnancies _____ # of Births ____

PMS Symptoms_____Birth Control Type _____ Last PAP _____

Breast Lumps Vaginal Sores Tract / Yeast / Candida Infection Other _____

Neuropsychological

Seizures Depression Anxiety Anger Stress Like to be in Control Bad Temper

Considered/Attempted Suicide Tics/Tremors Changes in Memory Difficult to Make Decisions

Treated for Emotional Problems _____ Speech Problems Dreams/Nightmares

Emotional Tendencies- Grief / Joy / Worried / Angry / Fearful / Overthinking Fainting
Other _____

Musculoskeletal

Back Pain Neck Pain Muscle Pain Joint Pain Other_____

Broken Bones Difficulty Developing Muscle Limb Heaviness Tendons Achy/Stiff Spasms

Moving / Wandering Pain Atrophy Body Development- Fast / Normal / Slow

Numbness_____ Time of the Day Pain or Numbness is Worse_____

Describe Locations and Type of Pain _____
_____