CLIENT HEALTH HISTORY

Name:_____ Date of Birth:_____

Address:_____

Phone:_____ Email:_____

Emergency Contact:_____
_____

I. **GOALS**: What would you most like to achieve through your work with Selena Wooley, Acupuncture Physician?
   1. _____
   2. _____
   3. _____

II. **MAJOR SYMPTOMS**: Please list the symptoms that are of concern for you (*most concerning to least, along with duration of symptom)*
   1. _____
   2. _____
   3. _____
   4. _____
   5. _____

III. **TREATMENT APPROACHES TO DATE**: Please list the therapies you have tried and how successful they have been.
   1. _____
   2. _____
   3. _____
   4. _____
   5. _____

IV: **MEDICATIONS/SUPPLEMENTS**: Please list all meds/vitamins/supplements that you are currently taking

   _____
   _____
   _____
   _____
   _____

V. **ALLERGIES**: Please list allergies (to medications/foods/latex/environmental, etc.)

   _____

VI. **SURGICAL HISTORY**: Please list all surgeries and procedures you have had along with the dates performed.

_____
_____
_____
_____
_____

VII. **FAMILY HISTORY**: Please check all that apply and state how you are related to the family member with that condition.

[ ] Heart disease
[ ] Hypertension
[ ] Asthma
[ ] Depression
[ ] Substance Abuse
[ ] Dementia
[ ] Cancer
[ ] Stroke
[ ] Allergies
[ ] Anxiety
[ ] Diabetes
[ ] Other

YOUR HEALTH HISTORY: Please check all that apply.

GENERAL

[ ] Poor appetite
[ ] Fatigue
[ ] Sweat easily
[ ] Bleed or bruise easily
[ ] Excessive appetite
[ ] Recurrent fevers
[ ] Chills
[ ] Edema
[ ]Insomnia
[ ]Night sweats
[ ] Strong Thirst
[ ] Memory issues
[ ] Other:_____

SKIN & HAIR

[ ] Rashes
[ ] Eczema
[ ] Thinning Hair
[ ] Hives
[ ] Acne
[ ] Psoriasis
[ ] Itching
[ ] Dryness
[ ] Excess hair growth
[ ] Other: _____

HEAD & NECK

[ ] Dizziness
[ ] Fainting
[ ]Concussions

[ ] Headaches
[ ] Migraines
[ ] Head trauma
[ ] Enlarged lymph nodes
[ ] Other: _____

EYES

[ ] Blurred vision
[ ] Poor night vision
[ ] Cataracts
[ ] Glasses/Contacts
[ ] Spots/Floaters
[ ] Dryness
[ ] Excessive tears
[ ] Other: _____

EARS

[ ] Infections
[ ] Ringing (Tinnitus)
[ ] Hearing Aids
[ ] Difficulty hearing
[ ] Other: _____

NOSE/THROAT/MOUTH

[ ] Nose bleeds
[ ] Sinus infections
[ ] Hay fever
[ ] Recurring sore throats
[ ] Grinding teeth
[ ]TMJ pain
[ ] Difficulty swallowing
[ ] Bleeding gums
[ ] Mouth sores
[ ] Other: _____

CARDIOVASCULAR

[ ] High blood pressure
[ ] Low blood pressure
[ ] Blood clots
[ ] Palpitations
[ ] Phlebitis
[ ] Chest pain
[ ] Irregular heart beat
[ ] Cold hands/feet
[ ] Pacemaker
[ ] High cholesterol
[ ] Other: _____

RESPIRATORY

[ ] Difficulty breathing
[ ] Asthma
[ ]Bronchitis
[ ] Frequent colds
[ ] COPD
[ ] Pneumonia
[ ] Cough
[ ] Coughing blood
[ ] Phlegm
[ ] Apnea/CPAP
[ ] Other: _____

GASTROINTESTINAL

[ ] Nausea
[ ] Vomiting
[ ] Diarrhea
[ ] Constipation
[ ] Belching
[ ] Flatulence
[ ] Blood in stools
[ ] Rectal pain
[ ] Hemorrhoids
[ ] Pain with elimination
[ ] Indigestion
[ ] Reflux
[ ] Gallbladder disorder
[ ] Other: _____

GENITO-URINARY

[ ] Kidney stones
[ ] Pain w/ urination
[ ] Frequent urination
[ ] Urgency
[ ] Blood in urine
[ ] Incontinence
[ ] UTIs
[ ] Other: _____

ENDOCRINE

[ ] Diabetes
[ ] Hormone imbalances
[ ] Thyroid disease
[ ] Cancer
[ ] Other: _____

MALE

[ ] Pain in genitalia [ ] Impotence [ ] Prostate issues
[ ] Other: _____

FEMALE

[ ] Bacterial infections [ ] Yeast infections [ ] Hot flashes
[ ] Pain/itching of genitalia [ ] Discharge [ ] Abnormal pap
[ ] Irregular menses [ ] Painful menses [ ] Endometriosis
[ ] PMS [ ] Spotting [ ] Breast lumps
[ ] Menopause [ ] Other: _____

NEUROLOGICAL

[ ] Seizures [ ] Numbness/Tingling of limbs [ ] Nerve pain
[ ] Paralysis [ ] Other: _____

PSYCHOLOGICAL

[ ] Depression [ ] Anxiety [ ] Irritability
[ ] Undergoing treatment for emotional issues [ ] High stress
[ ] Other: _____

INFECTION SCREENING

[ ]HIV/AIDS [ ] TB [ ] Hepatitis
[ ] Gonorrhea [ ] Chlamydia [ ] Syphilis
[ ] Genital Warts [ ] Herpes: Oral [ ] Herpes: Genital
[ ] Herpes Zoster: Shingles

MUSCULOSKELETAL

[ ] Stiff neck/shoulders [ ] Low back pain [ ] Back pain
[ ] Muscle spasms/twitching/cramps [ ] Joint pain
[ ] Herniated disks [ ] Broken Bones [ ] MS

GENERAL

PLEASE ANSWER THE FOLLOWING TO THE BEST OF YOUR ABILITY:

Sleep:

What time do you go to bed? _____
What time do you wake? _____
Is it easy to fall asleep? _____
Is it easy to stay asleep? _____
Do you wake to use the restroom? _____ If yes, how many times? _____
Do you dream? _____

Nutrition:

Do you follow a special diet? (Vegan, Vegetarian, Gluten/Dairy/Soy Free, Paleo, South Beach, Atkins, Macros, etc.) _____

Do you have a preference for warm or cold drinks? _____

How many cups of coffee per day do you drink? _____

Do you drink soda/tea (including herbal)/energy drinks? _____

Do you crave a particular flavor or food? _____

Are there any flavors/foods that you have an aversion to? _____

How many bowel movements do you have per day? _____

Please circle all that apply to your bowel movements:

Loose	Firm	Pellet-like	Dry
Bloody in stool	Mucus in Stool	Especially smelly	Pain/Cramps
Straining	Hemorrhoids	Undigested Food	

Exercise:

What kind of regular exercise do you participate in? _____

_____

Did/do you play sports? _____

Social History:

Occupation: _____

How many alcoholic beverages per week do you consume? _____

Do you smoke or have a history of smoking? _____

Do you use recreational drugs? _____

What is your primary emotion? _____

Have you ever been treated for emotional issues? _____

Have you ever considered or attempted suicide? _____

Other:

Are you pregnant or suspect you may be? _____

Do you have a pacemaker? _____

What is your energy level on a scale of 1-10 (10 being the highest)? _____

What is your pain level on a scale of 1-10 (10 being the highest)? _____

What is your stress level on a scale of 1-10 (10 being the highest)? _____

WOMEN'S MENSTRUAL/PREGNANCY HISTORY:

Are you currently pregnant? [ ] yes [ ] no [ ] unsure

Pregnancy history:
# of live births:
# of miscarriages:
# of abortions:

Age of menarche (when you first started menstruating): _____

Age of menopause: _____

Date of your last Pap Smear: _____

Date of your last Mammogram/Thermography: _____

Any history of abnormal Pap or Mammogram? _____

Date of your last menstrual period: _____

Are you currently on birth control? _____

What birth control have you used in the past? _____

Menses:
Length of cycle (first day of your period is day 1): _____
Are your cycles regular or irregular? _____
How many days do you bleed? _____
Any PMS or cramps? _____
Any clots? _____
What type of menstrual products do you use? _____