HEALTH HISTORY

Harmonic Healing Acupuncture

NAME: _____DATE: _____DATE OF BIRTH:_____
Reason for/ goals for visit: _____
_____
_____
How long have you had this condition?_____ Is it getting worse? _____
What seemed to be the initial cause?_____
What seems to make it better? Worse?_____
Have you received any other sort of treatment for this condition? _____
Do you take any nutritional supplements, vitamins, or herbs? _____ If so, which ones? (Please be specific with dosage).
_____
_____
_____
Which prescription and over the counter medications do you take regularly? _____
_____
_____
_____

Rank your skin without lotion? □ Very Dry □ Dry □ Normal □ Oily □ Combination
Do you have any of the following?

- o Itchy skin
- o Eczema
- o Psoriasis
- o Bruise easily
- o Hives
- o Acne
- o Foliculitis
- o Fungal infection
- o Ulcerations
- o Dandruff
- o Hair loss
- o Hair/nail changes
- o Poor nail growth
- o Jaundice
- o Other_____

Daily energy level: □ Excellent □ Good □ Fair □ Poor Scale of 1-10 (10=high): _____
What time of day do you have the most energy?_____ Do you have afternoon lows?_____

Sleep:

- o Insomnia
- o Difficult to fall asleep
- o Difficult staying asleep
- o Difficult to wake in the morning
  How many hours do you sleep? _____
- o Excessive sleep
- o Not rested in the morning
- o Vivid dreams
- o Don't remember dreams
- o Nightmares
- o Wake same time every night (Time?_____)
- o Irregular sleep pattern

Please check off any of the following that pertain to you

Medical Condition, past or present:

- o Addiction (alcohol, drugs)
- o Anorexia
- o Appendicitis
- o Arteriosclerosis
- o Anemia
- o Cancer (Type? _____)
- o Diabetes I (insulin dependent)
- o Diabetes II (adult onset)
- o Emphysema
- o Epilepsy/seizures
- o Fibromyalgia
- o Gout
- o Goiter
- o Gall bladder problems/stones
- o Head trauma/concussion
- o HIV/AIDS
- o Hepatitis (Type?_____)
- o High Cholesterol
- o Herpes simplex or type II
- o Heart disease or surgery
- o Kidney stones
- o Lupus
- o Multiple Sclerosis
- o Malaria
- o Mumps
- o Scarlet fever
- o Rheumatic fever
- o Pacemaker (Date?)
- o Pleurisy
- o Pneumonia
- o Polio
- o Shingles
- o Stroke
- o Thyroid condition
- o Tuberculosis
- o Typhoid fever
- o Whooping cough

Your Lifestyle:
Check any that apply:

- o Caffeine
- o Alcohol
- o Tobacco
- o Drugs
- o Marijuana
- o Soft drinks
- o Excessive sugar
- o Vegetarian
- o Vegan
- o Raw foods diet
- o Occupational hazards
- o High Stress
- o Regular exercise
- o Food allergies

Do you crave any of the following?
□Sugar □Meat □Chocolate □Cheese □Alcohol □Milk □Bread □Fried foods □Salt □Other _____

General Symptoms:

- o Fatigue
- o Lack of strength
- o Chill easily
- o Heat/cold intolerance
- o Cold hands/feet
- o Hot flashes
- o Spontaneous sweating
- o Nightsweats
- o Recent weight change
- o Bodily heaviness
- o Muscle cramps/twitches

Respiratory, Head, EENT:

- o Light-headedness
- o Fainting
- o Headaches
- o Migraines
- o Dizziness/Vertigo
- o Facial pain
- o Bell's Palsy
- o Loss of sensation
- o Problems with speech
- o Facial tics
- o Lack of coordination
- o Tremors
- o Glasses/contacts
- o Floaters
- o Stigmatism
- o Blurry vision
- o Eye pain
- o Itchy/red eyes
- o Glaucoma
- o Cataracts
- o Ringing in ears
- o Hearing loss
- o Recurring ear infections
- o Ears clogged
- o Allergies
- o Sinus congestion
- o Sinusitis
- o Post nasal drip
- o Asthma/wheezing
- o Bronchitis
- o Colds or flu (frequent)
- o Difficulty breathing
- o Tight chest
- o Cough
- o Coughing blood
- o Nose bleeds
- o Tooth ache
- o Dentures
- o Cold sores
- o Dry mouth
- o Excessive saliva
- o Difficult to swallow
- o Lump in throat
- o Recurrent sore throat
- o Sensitive to taste/smells
- o Swollen glands
- o Peculiar taste (describe_____)
- o Bleeding gums
- o TMJ/ Jaw pain
- o Clenching/grinding teeth
- o Shortness of breath without exertion

Cardiovascular:

- o High blood pressure (medicated?_____)
- o Low blood pressure
- o Poor circulation
- o Swelling of hands/feet
- o Blood clots
- o Chest pain
- o Reynaud's disease
- o Tachycardia
- o Heart murmur
- o Irregular heartbeat
- o Palpitations
- o Spider veins
- o Varicose veins
- o Deep Vein Thrombosis
- o Taking blood thinners

Gastrointestinal/Digestion:

- o Bloating
- o Gas
- o Abdominal pain/cramps
- o Acid reflux/heartburn
- o Recurring hiccups
- o Bloody stools
- o Undigested food in stool
- o Constipation
- o Colitis
- o IBS
- o Pain with bowel movements
- o Difficulty loosing weight
- o Difficulty gaining weight
- o Diarrhea
- o Hemorrhoids
- o Hernia
- o Ulcer
- o Parasites
- o Poor appetite
- o Heavy appetite
- o Nausea/vomiting
- o Belching
- o Regular laxative use

How many bowel movements do you have a day? _____
How many glasses of water do you drink/day?_____ Have you been excessively thirsty?_____

Musculoskeletal:

- o Neck/shoulder pain
- o Low back pain
- o Upper back pain
- o Spasms/cramping
- o Joint pain (knee, elbow, wrist, ankle)
- o Rib pain
- o Numbness _____
- o Arthritis (rheumatoid or osteo)
- o Trauma/injury
- o Restless leg syndrome
- o Surgery
- o Swelling
- o Weakness

Neuropsychological:

- o Anxiety or nervousness
- o Depression
- o Anxiety
- o Irritability
- o Easily stressed
- o Memory loss/confusion
- o Panic attacks
- o Suicidal thoughts/attempts
- o Severe mood swings

Genitourinary:

- o Bladder infection
- o Frequent urination
- o Difficulty/pain with urination
- o Urgency with urination
- o Wake at night to urinate
- o Incontinence
- o Blood in urine
- o Incomplete urination
- o Increased libido
- o Decreased libido
- o Premature ejaculation
- o Difficulty with erection
- o Prostate enlargement
- o Testicular pain

tes

Gynecological:

- o Yeast infection
- o Vaginal odor
- o Vaginal dryness
- o Menopause
- o PMS
- o Fibroids
- o Endometriosis
- o Irregular periods
- o Painful periods
- o Loss of periods
- o Hysterectomy
- o Pregnant/ nursing
- o Painful Intercourse
- o Infertility
- o Birth control pills
- o Other contraceptive_____
- o Breast lumps/swelling
- o Breast pain
- o Cystic breasts
- o Other _____

Are you still menstruating? Yes_____No_____ If so, where are you in your cycle presently? _____
Length of cycle?(Day 1 – Day 1)_____Duration of menses/flow? _____
Number of pregnancies?_____ Have you had any miscarriages?_____ Are you currently trying to conceive?_____
Are you perimenopausal?_____ Symptoms:_____
Are you menopausal?_____ Symptoms:_____

Please list any disease, illness, or ailments in your immediate family (i.e. mother – breast cancer, father – type II diabetes)

_____
_____
_____
_____
_____

Please describe any health concerns you think are important: _____
_____
_____
_____
_____
_____

By signing below, you acknowledge that any dietary or supplemental suggestions made by Michelle Wilson, L.Ac. are entirely nutritional in nature, and are not intended as the diagnosis, cure or treatment for any disease or ailment. You also acknowledge that your physician is your primary health care provider, and that he/she is aware of any medical conditions mentioned above, and is responsible for supervising all changes in diet and nutrient intake that you make.

Signed: _____ Date: _____