Elements of Health

76 N. Main Street, Ste. 204, Driggs, ID 83422

(208) 920-0312

Name: ____ Date: ______/______/______
(first) (middle) (last)

Address: ____ Phone:______________ /______________
street address city zipcode home / cell

Date of Birth: _______/_______/_______ Age: _______ Gender: M/F Marital status: S M/P D W

Emergency Contact:____
(name) (phone number) (relationship)

Successful health care and preventative medicine are only possible when the practitioner has a complete understanding of the patient physically, mentally and emotionally. Please complete this questionnaire as thoroughly as possible. Print all information and indicate areas of confusion with a question mark. Thank you.

When and where did you last receive health care? ____

For what reason? ____

Have you received acupuncture / Chinese herbs in the past? If so, with whom and when? ______________________

Please identify the health concerns that have brought you to *Elements of Health* in order of importance below:

Health concern(s) /**Past Treatment for this concern(s)** (please describe)

1. ____

____

2. ____

____

3. ____

____

4. ____

____

If applicable, please list any foods, drugs, or medications you are hypersensitive or allergic to (please include reaction):

____

____

Please list any medications (prescribed and over-the-counter), vitamins, and supplements you are currently taking:

____

____

____

Do you have any reason to believe you may be pregnant? Y N

If so, how far along are you? ____

Do you have any infectious diseases? Y N If yes, please identify: ________________________

Blood Pressure: What is your most recent blood pressure reading? _______/_______ When was this reading taken? ________

Hospitalizations and Surgeries:

Reason	When	Reason	When

Emotional (please *circle* any that you experience now and underline any that you have experienced in the past):

Mood Swings Nervousness Mental Tension / Stress Insomnia

Energy and Immunity (please *circle* any that you experience now and underline any that you have experienced in the past):

Fatigue Slow Wound Healing Chronic Infections Chronic Fatigue Syndrome

Head, Eye, Ear, Nose, and Throat (please *circle* any that you experience now and underline any that you have experienced in the past):

Impaired Vision	Eye Pain/Strain	Glaucoma	Glasses/Contacts	Tearing/Dryness
Impaired Hearing	Ear Ringing	Earaches	Headaches	Sinus Problems
Nose Bleeds	Frequent Sore Throats	Teeth Grinding	TMJ/Jaw Problems	Hay Fever

Respiratory (please *circle* any that you experience now and underline any that you have experienced in the past):

Pneumonia   Frequent Common Colds   Difficulty Breathing   Emphysema

Persistent Cough   Pleurisy   Asthma   Tuberculosis

Shortness of Breath   Other Respiratory Problems: ____

Cardiovascular (please *circle* any that you experience now and underline any that you have experienced in the past):

Heart Disease   Chest Pain   Swelling of Ankles   High Blood Pressure

Palpitations/Fluttering   Stroke   Heart Murmurs   Rheumatic Fever   Varicose Veins

Gastrointestinal (please *circle* any that you experience now and underline any that you have experienced in the past):

Ulcers   Changes in Appetite   Nausea/Vomiting   Epigastric Pain   Passing Gas   Heartburn

Belching   Gall Bladder Disease   Liver Disease   Hepatitis B or C   Hemorrhoids   Abdominal Pain

How many times a day do you have a bowel movement?____________   Does it feel complete?______________

Are your bowel movements (please circle)   Formed   Loose   Hard   Alternating   Difficult

Any blood or mucus in your stool?_____________

Genito-Urinary Tract (please *circle* any that you experience now and underline any that you have experienced in the past):

Kidney Disease   Painful Urination   Frequent UTI   Frequent Urination   Heavy Flow

Kidney Stones   Impaired Urination   Blood in Urine   Frequent Urination at Night

What is the color of your urine generally?__________________

Female Reproductive/Breasts (please *circle* any that you experience now and underline any that you have experienced in the past):

Irregular Cycles   Breast Lumps/Tenderness   Nipple Discharge   Heavy Flow

Vaginal Discharge   Premenstrual Problems   Clotting   Bleeding Between Cycles

Menopausal Symptoms   Difficulty Conceiving   Painful Periods   Mid-cycle pain

Hot Flashes   Night Sweats   Sexual Difficulties

Menstrual/Birthing History:

1. Age of First Menses: _______
2. # of Days of Menses: _______
3. Length of Cycle: _______
4. Birth Control Type: ________
5. # of Pregnancies: ________
6. # of Live Births: ________
7. Age of menopause_______

Male Reproductive (please *circle* any that you experience now and underline any that you have experienced in the past):

Sexual Difficulties Prostrate Problems Testicular Pain/Swelling Penile Discharge

Neurologic (please *circle* any that you experience now and underline any that you have experienced in the past):

Vertigo/Dizziness Paralysis Numbness/Tingling Loss of Balance Seizures/Epilepsy

Headaches How often_____________ Location_________________________ Type of Pain________________

Endocrine (please *circle* any that you experience now and underline any that you have experienced in the past):

Hypothyroid Hypoglycemia Hyperthyroid Diabetes Mellitus Night Sweats Feeling Hot or Cold

Pain Location(s):____

How long have you had this?______________________ Better with (please circle) Heat Cold Massage

Type of pain (please circle) dull ache sharp stabbing other (please describe)______________________________

____

____

Other (please *circle* any that you experience now and underline any that you have experienced in the past):

Anemia Cancer Rashes Eczema/Hives Cold Hands/Feet

Is there anything else we should know? ____

____

Lifestyle:

a. Do you typically eat at least three meals per day? Y N If no, how many? ____________________

In general describe your diet____

How many glasses of water do you drink per day? _________________________

How do you feel after a meal? Energized Bloated Gassy other:______________________________

b. Nicotine/Alcohol/Caffeine/Drug use (please list): ____

c. Do you ever have spontaneous perspiration?_______________________ Night sweats?______________________

d. Exercise routine/ how often: ____

e. Spiritual practice: ____

f. How many hours per night do you sleep? ________ Do you wake rested? Y N

Do you have trouble falling asleep?_________ Trouble waking?_________ Do you wake at night?_________

g. Occupation: ____________________________________ Hours worked /week: _________

Do you enjoy work? Y/N Why/Why not? ____

h. Have you experienced any major traumas? Y N Explain: _____________________________________

____

i. How did you hear about us?____

____ ____

Signature E-mail address