



Elements of Health

55 S. Main Street, Driggs, ID 83422

(208) 920-0312

Name: _____
(first) (middle) (last)

Date: ____/____/____

Address: _____
street address city zipcode

Phone: _____
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:

<u>Reason</u>	<u>When</u>	<u>Reason</u>	<u>When</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

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 Bloating 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