Elements of Health
55 S. Main Street, 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

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

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?_____

Apart from the usual medical details, it is important that you let your practitioner know: **(PLEASE CIRCLE)**

- if you have ever experienced a fit, or faint **Y /N**
- if you have a pacemaker or any other electrical implants **Y /N**
- if you have a bleeding disorder **Y /N**
- if you are taking anti-coagulants or any other medications **Y /N**
- if you have damaged heart valves or have any other particular risk of infection **Y /N**
- if you are pregnant **Y /N**

_____ _____

Signature E-mail address