BOULDER FAMILY ACUPUNCTURE 2955 Valmont St, Ste.100, Boulder, CO 80301 (303) 859-7556

Patient Health History

Name: ______________________________ Date: ________________

Date of Birth: ______________ Age: ______ Gender: ______ Marital status: ____________

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.

1. When and where did you last receive health care? ______________________________

For what reason? ______________________________

2. Has your case been referred to an attorney? ____Y ____N

3. Please identify the health concerns that have brought you to our clinic in order of importance below:

Condition	Past Treatment
a. ____________	____________
How does this condition affect you? ____________	
b. ____________	____________
How does this condition affect you? ____________	
c. ____________	____________
How does this condition affect you? ____________	
d. ____________	____________
How does this condition affect you? ____________	

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

____

____

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

____

____

____

6. Do you have any infectious diseases? ____ Y ____ N If yes, please identify: ______________________________

7. **Family History:**

Check those applicable:	Father	Mother	Brothers	Sisters	Spouse	Children
Age (if living)	_______	_______	_______	_______	_______	_______
Health (G=Good, P=Poor)	_______	_______	_______	_______	_______	_______
Cancer	_______	_______	_______	_______	_______	_______
Diabetes	_______	_______	_______	_______	_______	_______
Heart Disease	_______	_______	_______	_______	_______	_______
High Blood Pressure	_______	_______	_______	_______	_______	_______
Stroke	_______	_______	_______	_______	_______	_______
Mental Illness	_______	_______	_______	_______	_______	_______
Asthma/Hay fever/Hives	_______	_______	_______	_______	_______	_______
Kidney Disease	_______	_______	_______	_______	_______	_______
Age (at death)	_______	_______	_______	_______	_______	_______
Cause of Death	_______	_______	_______	_______	_______	_______

8. **Height:** ___________ **Weight:** Currently: ___________

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

10. **Illness** (please check any that you have had):

____ Scarlet Fever ____ Diphtheria ____ Rheumatic Fever ____ Mumps ____ Measles ____ Chicken Pox

____ Cancer (___________________) ____ Kidney disease ____ Liver Disease ____ Diabetes ____ Heart Disease

____ High Blood Pressure ____ Stroke ____ Mental Illness ____ Addiction ____ Asthma

____ Allergies – (____) ____ Autoimmune Disease – (_____________________)

11. **Hospitalizations and Surgeries:**

Reason	When	Reason	When
______________________________	__________	______________________________	__________
______________________________	__________	______________________________	__________
______________________________	__________	______________________________	__________

12. **X-Rays/CAT Scans/MRI's/NMR's/Special Studies:**

Reason	When	Reason	When
______________________________	__________	______________________________	__________
______________________________	__________	______________________________	__________
______________________________	__________	______________________________	__________

13. **Put a check mark by the symptoms that pertain to you.**

____Cold Hands/Feet
____ Fatigue
____Feverish In The Afternoon Or Flushes
____Heat Sensations In Hands, Feet, Chest
____Night Sweats
____ Catch Colds Easily
____ Sweat Easily
____ Dizziness
____ See Floating Black Spots
____Palpitations
____Sore On Tip Of Tongue
____ Restlessness
____ Anxiety
____ Chest Pain Radiating To Shoulder
____ Insomnia
____ Cough
____ Sinus Congestion
____ Dry Mouth, Throat, Nose Or Skin
____ Allergies
____Chills Alternating With Fever
____Stiff Neck/Shoulders
____ Sore Throat
____ Difficult Breathing
____ Low Appetite
____ Loose Stools
____ Constipation
____ Abdominal Bloating And/Or Gas After Eating
____ Feeling Tired After Eating
____ Prolapsed Organs (Previously Diagnosed)
____Bruise Easily
____General Feeling Of Heaviness In Body
____Mental Heaviness, Sluggishness Or Fogginess
____Swollen Hands/Feet
____ Burning Sensation After Eating
____ Large Appetite
____ Bad Breath
____ Mouth (Canker) Sores
____ Bleeding, Swollen Painful Gums

____ Heartburn/Belching
____ Stomach Pain
____Vomiting
____Diarrhea Alternating With Constipation
____Tight Feeling In Chest
____Bitter Taste In Mouth
____ Blood Shot Eyes/Dry Eyes
____ Anger Easily
____ Irritability
____ Skin Rashes
____ Headache - Location: ______________
____ Numbness Of Hands And Feet
____Muscle Spasms, Twitching, Cramping
____ Seizures/Convulsions
____ Sore, Cold Or Weak Knees
____Low Back Pain
____ Frequent Urination
____ Get Up More Than Once A Night To Urinate
____ Lack Of Bladder Control
____ Memory Problems
____Hair Loss
____Ringing In Ears
____Urine Is:
    ____ Normal Color
    ____ Clear
    ____Dark Yellow
    ____Reddish
    ____Cloudy
    ____ Scanty
    ____ Has Odor
    ____ Burning
    ____ Painful
    ____ Difficult
    ____ Urgent
____Libido (Sex Drive) Is:
    ____Normal
    ____ Low
    ____High

14. Women only

Please answer each question or check the appropriate response.
1. Are you pregnant now? ____Yes ____No If so, how far along? _______ weeks
2. Number of Children __________
3. Number of pregnancies ______
4. Age of first period __________
5. Age of menopause (if applicable) __________
6. Is your menses regular? ____ Yes ____No

Average number of days of flow __________
Average number of days of cycle _________
The flow is: ____ Normal ____Heavy ____Light
The color is:
____Normal ____Dark ____ Purple ____Light Brown ____Brown ____Other_______________
Do you have the following menstruation related signs/symptoms?
____Blood clots Approximate size _______________ Color __________________
____Cramps
____Nausea
____Breast distension

____PMS
____Bleeding between periods
____Heavy vaginal discharge between periods
Color: ________________________

Other information that you think I should know about:

____
____
____

15. **Men Only**

Please put a check mark by the symptoms that pertain to you.

____ Feeling of coldness or numbness in external genitalia.
____Pain or swelling of testicles
____Premature ejaculation
____Impotence/erectile dysfunction

Other information that you think I should know about:

____
____
____

16. **Lifestyle:**

a. Do you typically eat at least three meals per day? ____Y ____ N If no, how many? ________________

b. Typical day's diet: ____

____

c. Exercise routine: ____

d. How many hours per night do you sleep? ________ Do you wake feeling rested? ____ Y ____N

e. Occupation: ____________________________ Employer: ____________________ Hours/Week: _______

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

f. Nicotine/Alcohol/Caffeine Use: ____

g. Have you experienced any major traumas? ____Y ____ N Explain: ______________________________

____

____

h. How many ounces of non-caffeinated, non-carbonated beverages do you drink per day? ___________

i. Interests and hobbies: ____