



**Patient Health History**

Please complete this questionnaire as thoroughly as possible so we can create the best treatment plan for you. All your answers will be held absolutely confidential. If you have any questions about this form, please ask.

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_\_ Gender: M F Weight: \_\_\_\_\_ Height: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone #: \_\_\_\_\_ Email: \_\_\_\_\_

Marital Status: single married divorced widowed partnered

Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

How did you hear about Marshall Acupuncture & Herb Clinic? \_\_\_\_\_

Have you ever used Chinese medicine for your health care? \_\_\_\_\_

If so, for what reason? \_\_\_\_\_

**MAIN CONCERNS**

Please indicate your top 3 health concerns and how long you have been experiencing them:

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

Western Medical Diagnosis, if any: \_\_\_\_\_

What goals would you like to achieve with our sessions? \_\_\_\_\_

**GENERAL HISTORY**

How many hours of sleep do you average each night? \_\_\_\_\_ Do you experience:  Difficulty falling asleep  
 Difficulty staying asleep  Wake up groggy, unrested  Nightmares  Vivid dreams  No dreams

How many bowel movements do you average per day or week? \_\_\_\_\_

Are your bowel movements:  Well-formed  Loose/broken  Small pebbles  Skinny  Difficult to pass

Please list any medications, vitamins or supplements you are taking: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

List any serious illnesses, accidents or surgeries and the date they occurred: \_\_\_\_\_  
\_\_\_\_\_

Do you have any infectious diseases: Y / N If yes, please identify: \_\_\_\_\_

EMPLOYMENT

Occupation: \_\_\_\_\_ Company Name: \_\_\_\_\_

Most of the day is spent:  Sitting  Standing  Very active

Do you enjoy your work? Y / N What activities/hobbies do you most enjoy doing? \_\_\_\_\_

How would you rate your energy level on a scale from 1-10, with 10 being the highest: \_\_\_\_\_

How would you rate your stress level on a scale from 1-10, with 10 being the highest: \_\_\_\_\_

FAMILY MEDICAL HISTORY

Please check any condition that applies to your immediate family. Then put a F (father), M (mother), S (sister), B (brother), GM (grandmother), or GF (grandfather) next to the condition.

- |   |   |  |                                       |
|---|---|--|---------------------------------------|
| <input type="checkbox"/> Diabetes _____       | <input type="checkbox"/> Seizures _____     | <input type="checkbox"/> Heart Disease _____   | <input type="checkbox"/> Stroke _____ |
| <input type="checkbox"/> Cancer _____         | <input type="checkbox"/> Allergies _____    | <input type="checkbox"/> Mental Illness _____  | <input type="checkbox"/> Asthma _____ |
| <input type="checkbox"/> Kidney Disease _____ | <input type="checkbox"/> Lung Disease _____ | <input type="checkbox"/> Substance Abuse _____ |                                       |
| <input type="checkbox"/> Other: _____         |   |  |                                       |

PERSONAL HEALTH HISTORY

Please check any that you have or have had in the past year.

MUSCLE/JOINT/BONES

- |   |                                       |   |                                       |
|---|---------------------------------------|---|---------------------------------------|
| <input type="checkbox"/> Tremors                                  | <input type="checkbox"/> Arthritis    | <input type="checkbox"/> Swollen Joints | <input type="checkbox"/> Cramps       |
| <b>Pain, weakness, numbness in:</b> <input type="checkbox"/> Back | <input type="checkbox"/> Feet         | <input type="checkbox"/> Hips           |                                       |
| <input type="checkbox"/> Neck/shoulders                           | <input type="checkbox"/> Arms or legs | <input type="checkbox"/> Hands          | <input type="checkbox"/> Other: _____ |

EYES, EARS, NOSE, THROAT, RESPIRATORY

- |   |  |                                       |  |
|---|--|---------------------------------------|--|
| <input type="checkbox"/> Asthma/wheezing          | <input type="checkbox"/> Enlarged glands           | <input type="checkbox"/> Hoarseness   | <input type="checkbox"/> Persistent cough    |
| <input type="checkbox"/> Blurred or failed vision | <input type="checkbox"/> Eye dryness or irritation | <input type="checkbox"/> Gum trouble  | <input type="checkbox"/> Ringing in ears     |
| <input type="checkbox"/> Shortness of breath      | <input type="checkbox"/> Frequent colds            | <input type="checkbox"/> Nose bleeds  | <input type="checkbox"/> Sinus problems      |
| <input type="checkbox"/> Earaches                 | <input type="checkbox"/> Hay fever/allergies       | <input type="checkbox"/> Hearing loss | <input type="checkbox"/> Headaches/migraines |

SKIN & HAIR

- |   |   |  |  |
|---|---|--|--|
| <input type="checkbox"/> Itching/rash       | <input type="checkbox"/> Dry skin       | <input type="checkbox"/> Sweats easily         | <input type="checkbox"/> Bruise easily |
| <input type="checkbox"/> Boils              | <input type="checkbox"/> Sensitive skin | <input type="checkbox"/> Eczema                | <input type="checkbox"/> Hair loss     |
| <input type="checkbox"/> Slow wound healing | <input type="checkbox"/> Psoriasis      | <input type="checkbox"/> Brittle hair or nails | <input type="checkbox"/> Acne          |

GENITO/URINARY

- |   |   |   |  |
|---|---|---|--|
| <input type="checkbox"/> Blood/pus in urine | <input type="checkbox"/> Inability to control urine | <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Painful urination |
| <input type="checkbox"/> Frequent urination | <input type="checkbox"/> Kidney stones              | <input type="checkbox"/> Lowered libido | <input type="checkbox"/> Urinary dribbling |

CARDIOVASCULAR

- Chest pain
- Hardening of arteries
- High/low blood pressure
- Poor circulation
- Previous heart attack
- Swelling of ankles
- Irregular heartbeats
- Blood clots
- Palpitations/fluttering
- Heart murmurs
- Fainting
- Stroke

GASTROINTESTINAL

- Belching, gas, bloating
- Food allergies
- Constipation
- Diarrhea
- Difficulty swallowing
- Abdominal pain/cramps
- Poor appetite
- Excessive appetite
- Gallbladder trouble
- Hemorrhoids
- Acid reflux/GERD
- Nausea
- Vomiting
- Indigestion
- Liver disease
- Bad breath

EMOTIONAL/MENTAL

- PTSD/Trauma
- Depression
- Frequent crying
- Obsessive/compulsive
- Anxiety/Stress
- Mood swings
- Loneliness
- Eating disorder
- Addiction
- Excessive fear/worry
- Lack of motivation
- Pessimistic thinking
- Panic attacks
- Angry outbursts
- Suicidal thoughts

OTHER

- Anemia
- Bleeding disorder
- Colon polyps
- Dizziness
- Breast lump
- ADD/ADHD
- Fatigue/tiredness
- Cancer
- Night sweats
- Diabetes

FOR MEN ONLY

- Erection difficulties
- Prostate trouble
- Testicular pain/swelling
- STDs \_\_\_\_\_
- Penile discharge
- Interrupted urination
- Sexual difficulties

FOR WOMEN ONLY

- Bleeding between cycle
- Clots in menses
- Scanty menstrual flow
- STDs \_\_\_\_\_
- Heavy flow
- Extreme menstrual pain
- Breast tenderness
- Painful intercourse
- Irregular cycle
- Menopausal symptoms
- Ovarian cysts
- Excessive/odorous vaginal discharge
- PMS
- Previous miscarriage
- Fibroids

Could you be pregnant? Y / N

Is there anything else that you would like us to know before your treatment? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

SIGNATURE

The information on this form is correct to the best of my knowledge.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_