HeartSpace HEALTH HISTORY
Information for your Acupuncturist

Some of the questions that follow may seem unrelated to your condition;
they do, however, play a major role in diagnosis and treatment.
All information is strictly confidential.

I. **General Patient Information**

Date: ____/____/____

Name: _____

Address: _____

City, State, Postal Code _____

Email:_____ Add to HeartSpace email blast? Yes___ No ___

Primary Phone: _(_____)_____Alternate Phone: _(_____)_____

Age: _____ Date of Birth: ____/____/____ Guardian (if under 18) _____

Emergency contact & phone: _____

Gender: M F Height: ____'____" Weight: _____lbs. Blood Type_____

Occupation:_____Employer:_____

How did you hear about our office? _____

Major complaint(s), in order of significance to you:

1. _____ 4. _____
2. _____ 5. _____
3. _____ Additional: _____

How do these conditions impair your daily activities? _____

_____

II. **Patient Medical History**

How was your childhood health? _____

Hospital Visits/Stays: _____

Recent tests: (please indicate test results and date below

- ❑ Physical
- ❑ Blood (which?)
- ❑ Mammography
- ❑ Cholesterol
- ❑ HIV/STD
- ❑ Other:_____
- ❑ Prostate
- ❑ Pap smear

Test Results and Date: _____

Check any you have had in the past:

- ❑ Diabetes
- ❑ Allergies

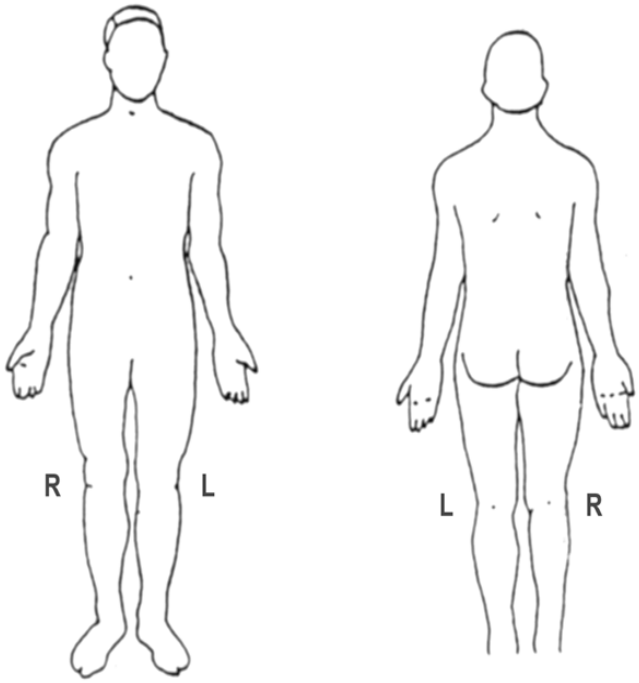
- ❑ Glaucoma
- ❑ Rheumatic Fever
- ❑ Heart Disease ❑CVA (stroke)
- ❑ Vein condition
- ❑ Thyroid disorder
- ❑ Asthma
- ❑ Pneumonia
- ❑ Tuberculosis
- ❑ Emphysema
- ❑ Jaundice
- ❑ Gonorrhea
- ❑ Mumps
- ❑ Bleeding tendency
- ❑ Syphilis
- ❑ Measles
- ❑ Chicken pox
- ❑ Nervous disorder
- ❑ Meningitis
- ❑ HIV
- ❑ Polio
- ❑ Mononucleosis
- ❑ Epilepsy
- ❑ High fever
- ❑ Hepatitis
- ❑ Multiple Sclerosis
- ❑ Paralysis
- ❑ Cancer
- ❑ Migraines
- ❑ High blood pressure
- ❑ other lung illnesses
- ❑ other liver illnesses
- ❑ other heart illnesses
- ❑ other kidney illnesses
- ❑ other:_____ _____

Immunizations: _____

Surgeries: _____

III. **Patient Profile**

Please clearly mark any areas of pain and any scars (please indicate which of the areas are scars):



Is the pain:

- ❑ Sharp
- ❑ Burning
- ❑ Aching
- ❑ Cramping
- ❑ Dull
- ❑ Moving
- ❑ Fixed
- ❑ Other:_____

Do the following improve the pain?

- ❑ Pressure
- ❑ Cold
- ❑ Heat
- ❑ Exercise
- ❑ Other:_____

Do the following worsen the pain?

- ❑ Pressure
- ❑ Cold
- ❑ Heat

- ❑ Other:_____

Please check the following that currently pertain to you (if you have symptoms in the following categories, it indicates that you have a problem with that organ's function):

Overall Temperature (Kidney function):

- ❑ Cold hands
- ❑ Cold fingers
- ❑ Cold feet
- ❑ Cold toes
- ❑ Sweaty hands
- ❑ Sweaty feet
- ❑ Hot body temperature (sensation)
- ❑ Cold body temperature (sensation)
- ❑ Afternoon flushes
- ❑ Night sweats
- ❑ Heat in the hands, feet, and chest
- ❑ Hot flashes any time of the day
- ❑ Thirsty
- ❑ Perspire easily
- ❑ Lack of perspiration
- ❑ Take water to bed

Overall energy (Lung, Kidney function):

- ❑ Shortness of breath
- ❑ Difficulty keeping eyes open in the daytime
- ❑ General weakness
- ❑ Easily catch colds
- ❑ Low energy
- ❑ Feel worse after exercise

Overall blood (Liver, Spleen, Heart function):

- ❑ Dizziness
- ❑ See floating black spot

Heart Function

- ❑ Palpitations
- ❑ Anxiety
- ❑ Sores on the tip of the tongue
- ❑ Restlessness
- ❑ Mental confusion
- ❑ Chest pain traveling to shoulder
- ❑ Frequent dreams
- ❑ Wake unrefreshed
- ❑ Drink coffee (# of cups per week: _____)

Lung function:

- ❑ Nasal Discharge (Color: _____)
- ❑ Cough
- ❑ Nose Bleeds
- ❑ Sinus Congestion
- ❑ Dry mouth
- ❑ Dry throat
- ❑ Dry Nose
- ❑ Dry Skin
- ❑ Allergies (To what? _____)
- ❑ Alternating fever and chills
- ❑ Sneezing
- ❑ Headache (Location: _____)
- ❑ Overall achy feeling in the body
- ❑ Stiff neck
- ❑ Stiff shoulders
- ❑ Sore throat
- ❑ Difficulty breathing
- ❑ Smoke cigarettes (# of cigarettes per day: _____)
- ❑ Sadness
- ❑ Melancholy

Spleen function:

- ❑ Low appetite
- ❑ Abrupt weight gain
- ❑ Abrupt weight loss
- ❑ Abdominal bloating
- ❑ Abdominal gas
- ❑ Gurgling noise in the stomach

- ❑ Fatigue after eating
- ❑ Easily bruised
- ❑ Hemorrhoids
- ❑ Pensive
- ❑ Prolapsed organs (previously diagnosed, which organ? _____
- ❑ Over-thinking
- ❑ Worry

Spleen, Stomach, Large Intestine, Small Intestine function:

- ❑ Loose
- ❑ Constipated
- ❑ Incomplete
- ❑ Diarrhea
- ❑ Blood in stools
- ❑ Mucous in stools
- ❑ Undigested food in stools

Dampness trapped in the body:

- ❑ General sensation of heaviness in the body
- ❑ Mental heaviness
- ❑ Mental sluggishness
- ❑ Mental fogginess
- ❑ Swollen hands
- ❑ Swollen feet
- ❑ Swollen joints
- ❑ Chest congestion
- ❑ Nausea
- ❑ Snoring

Stomach function:

- ❑ Burning sensation after eating
- ❑ Large appetite
- ❑ Bad breath
- ❑ Mouth (canker) sores
- ❑ Bleeding, swollen or painful gums
- ❑ Heartburn
- ❑ Acid regurgitation
- ❑ Ulcer (diagnosed)
- ❑ Belching
- ❑ Hiccoughs
- ❑ Stomach pain
- ❑ Vomiting

Liver, Gall Bladder function:

- ❑ Alternating diarrhea and constipation
- ❑ Chest pain
- ❑ Tight sensation in the chest
- ❑ Bitter taste in the mouth
- ❑ Anger easily
- ❑ Frustration
- ❑ Depression
- ❑ Irritability
- ❑ Frequently unable to adapt to stress (What causes the stress? _____ _____ _____)
- ❑ Skin rashes
- ❑ Headache at the top of the head
- ❑ Tingling sensation
- ❑ Numbness
- ❑ Muscle spasms
- ❑ Muscle twitching
- ❑ Muscle cramping
- ❑ Seizures
- ❑ Convulsions
- ❑ Lump in the throat
- ❑ Neck tension
- ❑ Limited Range-of-Motion, Neck
- ❑ Shoulder tension
- ❑ Limited Range-of-Motion, Shoulder
- ❑ Drink alcohol
- ❑ Recreational drugs (Which? _____, How much per week? _____)
- ❑ High-pitched ringing in the ears
- ❑ Gall stones (history or current)
- ❑ Sexually transmitted disease (Which? _____

Eyes (Liver function):

- ❑ Itchy
- ❑ Bloodshot
- ❑ Hot
- ❑ Dry
- ❑ Watery
- ❑ Far-sighted
- ❑ Gritty
- ❑ Blurry vision
- ❑ Decreased night vision
- ❑ Near-sighted

Kidney, Urinary Bladder function:

- ❑ Frequent cavities
- ❑ Easily broken bones
- ❑ Sore knees
- ❑ Weak knees
- ❑ Cold sensation in the knees
- ❑ Low back pain
- ❑ Memory problems
- ❑ Excessive hair loss
- ❑ Low-pitched ringing in the ears
- ❑ Kidney stones
- ❑ Bladder infections
- ❑ Wake during the night twice or more to urinate
- ❑ Lack of bladder control
- ❑ Fear
- ❑ Easily startled

Urination:

- ❑ Normal color
- ❑ Dark yellow
- ❑ Clear
- ❑ Reddish
- ❑ Cloudy
- ❑ Scanty
- ❑ Profuse
- ❑ Strong odor
- ❑ Burning
- ❑ Painful
- ❑ Discharge
- ❑ Difficult
- ❑ Painful
- ❑ Urgent
- ❑ Frequent

Libido:

- ❑ Normal
- ❑ High
- ❑ Low

Men only:

- ❑ Swollen testes
- ❑ Testicular pain
- ❑ Impotence
- ❑ Premature ejaculation
- ❑ Feeling of coldness or numbness in external genitalia

Women only:

Regular menstrual cycle? Y N
Pregnant? Y N
Number of children:_____
Number of pregnancies:_____
Age of first menstruation:_____
Age of menopause (if applicable):_____
Average number of days of flow:_____
Average number of days of entire cycle:_____
Vaginal discharge? Y N
Bleeding between periods? Y N

Do you experience any of the following pre-menstrual syndromes?

- ❑ nausea
- ❑ vomiting
- ❑ water retention
- ❑ breast swelling
- ❑ food cravings
- ❑ headaches
- ❑ migraines
- ❑ breast tenderness
- ❑ depression
- ❑ irritability
- ❑ anxiety
- ❑ other emotions:_____
- ❑ dull pain, where?_____
- ❑ sharp pain, where?_____

Please fill in the following menstrual chart:

	Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7
Color (normal, bright red, pale, brown, rust, dark, purple, other)							
Amount of flow (normal, heavy, light)							
Pain/cramps (location, dull, sharp, other)							
Clots (large, small, black, purple, red, other)							
Vomiting (check if yes)							
Nausea (check if yes)							
Other							

All please fill out:

Other Comments: _____

_____

Patient Signature: _____

Acupuncturist Signature: _____