Healing Roots, LLC
Acupuncture Herbs & Massage

Patient Health History

****IMPORTANT: Filling out this form out as thoroughly as possible helps us to determine the best treatment plan for you, and all information you provide is completely CONFIDENTIAL. Please report any health changes, PREGNANCY, changes in insurance, or new PIP or LNI claims to us immediately!****

Name:_____Today's date:_____Cell phone:_____

Date of Birth:_____Age:____Height:_____Weight:_____Gender:_____Marital Status:_____

Occupation:_____How did you find out about Healing Roots?_____

Have you been treated by Acupuncture, Oriental Medicine, or Massage before?_____

When?_____With whom?_____For what condition?_____

Current Health Concerns and Medical History

What is your main goal in seeking treatment?_____

Are you looking for help with a chronic condition?____An acute problem?____Preventative Care?____

Which of the available therapies are you seeking: Acupuncture/Oriental Medicine?____Body Work?____

Herbal Medicine?_____Dietary/Lifestyle Counseling?_____Other?_____

Please list your health concerns (physical, emotional, and psychological) in order of priority:_____

Concerns	Known Cause	Date of Onset	% of Time	Severity (1 to 10)
1.				
2.				
3.				
4.				

To what extent do these problems interfere with your daily activities?_____

Are you seeing a Primary Care or other physician for your condition(s)?_____

Dr.'s name and speciality:_____Is this your PCP?_____

Dr.'s contact information :_____

What is their diagnosis?_____Recommended treatment?_____

Are you currently using any therapies to remedy your condition?_____

_____

Please list any medications (prescription or over the counter) and supplements that you are currently taking or have taken during the last two months (Please attach a list if there is not enough space below.) :

Medication/Supplement	Reason for Taking	Dates Taken	Dosage/Frequency
1.			
2.			
3.			
4.			

Do you have any allergies to medications, chemicals, foods, other?_____

Please list all past conditions for which you were hospitalized and/or received surgery (include dates):
These may include, but are not limited to, surgeries, significant trauma, adverse reaction to vaccine or medication, injury, childhood illness, dental work, and occupational stress:

_____

_____

_____

Please indicate if any of the following pertain to you: (indicating “yes” does not make you ineligible for treatment, however, it may restrict some of your treatment modalities):

Cancer	Diabetes	Heart Disease
Hepatitis	HIV	High Blood Pressure
Pacemaker	Seizures	STD’s
Pregnancy	Anaphylaxis	Rheumatic Fever
Clotting Disorder	Communicable Disease	Other:

Has anyone in your family suffered from the above conditions or other major illness not mentioned here?
Please indicate which family member and what their condition was: _____

Gynecological History

Are you currently experiencing any gynecological symptoms or problems?_____

How old were you at the onset of first mense?___What was the first day of your last period?_____

Menstrual pattern: Length of cycle?_____Length of period?_____Predicted ovulation day?_____

Are you currently trying to conceive?_____Are you currently pregnant?_____

How many pregnancies have you had?____How many births?____Miscarriages?____Abortions?_____

Are you perimenopausal?_____At what age did perimenopause begin?_____Are you on HRT?_____

Do you use birth control?____If yes, what kind and for how long?_____

Do you or anyone in your family have a history of cervical, ovarian, or breast cancer?_____

Lifestyle and Habits

Do you have a regular exercise program (please describe)?_____

Is it rigorous, moderate, or mild?_____Is it daily, weekly, monthly, or irregularly?_____

Do you smoke?_____If yes, what?_____How much per day?_____Since when?_____

Do you drink alcohol?_____If yes, what?_____How much?_____How often?_____

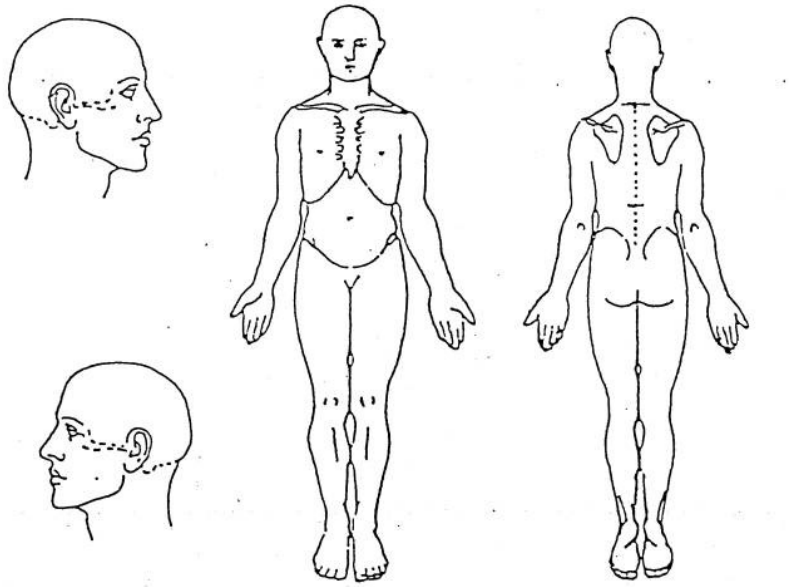
Do you drink caffeine?_____If yes, what?_____How much per day?_____

Have you ever been on a restricted diet?____If yes, please describe:_____

Please describe your average daily diet:

Breakfast	Lunch	Dinner	Snacks (time?)

Please indicate painful or distressed areas on the diagram below:



	Pain on Pressure	Swelling	Tension or Weakness	Spontaneous Pain	Pulsing	Temperature	Physical

Symbol	x	xx	xxx	)	))	)))	U		ǂ	o	oo	ooo	*	**	***	↓		↑	~	R	<>
Reaction	slight	medium	severe	slight	medium	severe	weak	normal	tense	slight	medium	severe	slight	medium	severe	colder	normal	hotter	sores	rashes	spasms

Please check any symptoms that you have had in the last three months:			
General	Glasses	**Respiratory**	Hip pain
Poor appetite	Poor vision	Cough	Other:
Fevers	Cataracts	Bronchitis	**Neuropsychological**
Sweat Easily	Dizziness	Difficulty breathing while lying down	Seizures
Localized weakness	Sinus Problems	Producing phlegm	Areas of numbness
Bleed or bruise easily	Grinding Teeth	What color?	Concussion
Peculiar tastes or smells	Teeth problems	Coughing up blood	Bad temper/mood swings
Strong thirst (hot or cold)	Concussions	Pneumonia	Foggy brain
Thirst, no desire to drink	Eye strain	Asthma	Lack of coordination
Sudden energy drop	Night blindness	Pain with a deep breath	Depression
What time of day?	Blurry vision	Other:	Easily stressed
Poor sleeping/insomnia	Poor hearing	**Gastrointestinal**	Loss of balance
Chills	Nose bleeds	Nausea	Poor memory
Tremors	Facial pain	Constipation	Anxiety
Poor balance	Jaw clicks	Bad breath	Other:
Fatigue	Eye pain	Abdominal pain/cramps	**Genito-Urinary**
Night sweats	Color blindness	Chronic laxative use	Often waking to urinate
Cravings	Earaches	Vomiting	Pain upon urinating
Change in appetite	Spots in front of eyes	Gas/bloating	Urgency to urinate
Weight gain	Ringing in ears	Blood in stools	Decrease in flow of urine
Weight loss	Sores on lips or tongue	Rectal pain	Frequent urination
Skin and Hair	Recurrent sore throats	Diarrhea	Unable to hold urine
Rashes	Other:	Belching	Blood in urine
Itching	**Cardiovascular**	Indigestion	Kidney stones
Dandruff	Pacemaker	Hemorrhoids	Sores on genitals
Change in hair or skin	Blood thinning disease	Bowel movements:	Impotency
Ulcerations	Irregular heartbeat	Frequency:	Urine color?
Eczema	Cold hands or feet	Consistency:	Other:
Hair loss	Blood clots	Other:	**Gynecological**
Hives	Low blood pressure	**Musculoskeletal**	PMS
Pimples	Dizziness	Neck pain	Clots
Recent moles	Swollen hands	Back pain	Vaginal sores
Other:	Phlebitis (inflamed vein)	Hand or wrist pain	Breast lumps
Head, Eyes, Ears,	Chest Pain	Muscle pains	Vaginal discharge
Nose and Throat	Fainting	Muscle weakness	Unusual bleeding
Headaches:	Swollen feet	Shoulder pain	Hot flashes
Where?	Difficulty breathing	Knee pain	Irregular menses
When?	Other:	Foot or ankle pain	Other: