

Patient Health History

PLEASE NOTE THAT ALL INFORMATION IS CONFIDENTIAL.

Name _____ Today's Date _____

Age _____ Date of Birth _____ SSN _____

Address _____

Phone # _____ email _____

Is it alright to leave a message about your care? Yes No

Emergency Contact _____

Relationship & Phone # _____

Physician _____ Phone# _____

How did you hear about my services? _____

Thank you for taking the time to fill out this form as completely as possible.
To give you the best possible care, it is essential for me to have a thorough
understanding of your past and present health.

What brings you in today? _____

When, how and where did this condition begin? _____

What types of treatment have you tried and what were the results? _____

How does this condition impact your daily activities? _____

Please list the main health problems you would like to address in order of importance:

1. _____

2. _____

3. _____

Please list any medications/vitamins/supplements you are currently taking.

Medication/dosage	Reason	For How Long
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_____	_____	_____
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_____	_____	_____
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_____	_____	_____
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Please list all surgeries, major illnesses, hospitalizations, and major accidents and when they occurred. _____

Please list any allergies and your response to them (medications, foods, animals, environmental substances, etc).

Please list any significant health conditions that have occurred in your family members.

condition: _____ relation to you: _____

Please circle any childhood conditions that you have had.

Scarlet Fever Diphtheria Rheumatic Fever Measles German Measles
Mumps Chicken Pox Childhood Asthma Other _____

Please circle or check all that apply.

0=never 1=rarely 2=occasionally 3=frequently 4=always

Energy and Immunity

- 0 1 2 3 4 fatigue
- 0 1 2 3 4 catch colds easily
- 0 1 2 3 4 slow wound healing
- 0 1 2 3 4 feel worse after exercise
- 0 1 2 3 4 chronic infection
- ___ HIV/AIDS
- other _____

Musculoskeletal

- 0 1 2 3 4 neck / shoulder pain
- 0 1 2 3 4 low back pain
- 0 1 2 3 4 mid back pain
- 0 1 2 3 4 upper back pain
- 0 1 2 3 4 arm pain
- 0 1 2 3 4 leg pain
- 0 1 2 3 4 muscle spasms / cramping
- 0 1 2 3 4 joint pain _____
- other _____

Gastrointestinal

- 0 1 2 3 4 digestive problems
- 0 1 2 3 4 low appetite
- 0 1 2 3 4 insatiable appetite
- 0 1 2 3 4 fatigue after meals
- 0 1 2 3 4 gas or bloating after eating
- 0 1 2 3 4 ulcers
- 0 1 2 3 4 acid reflux
- 0 1 2 3 4 nausea or vomiting
- 0 1 2 3 4 stomach pain
- 0 1 2 3 4 heartburn
- 0 1 2 3 4 belching
- 0 1 2 3 4 constipation
- 0 1 2 3 4 diarrhea
- 0 1 2 3 4 blood in stools
- 0 1 2 3 4 mucous in stools
- 0 1 2 3 4 undigested food in stools
- ___ parasites _____
- ___ liver disease
- ___ gall bladder disease
- ___ hepatitis B / C
- other _____

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Respiratory

- 1 2 3 4 cough
 - 1 2 3 4 asthma
 - 1 2 3 4 difficulty breathing
 - 1 2 3 4 pneumonia
 - emphysema
 - pleurisy
 - tuberculosis
 - other _____
-

Head, Eye, Ear, Nose, & Throat

- 1 2 3 4 headaches
 - 1 2 3 4 sinus congestion
 - 1 2 3 4 nasal discharge
 - 1 2 3 4 nose bleeds
 - 1 2 3 4 dry nose/mouth/throat
 - 1 2 3 4 sore throat
 - 1 2 3 4 bleeding or swollen gums
 - 1 2 3 4 floaters in vision
 - 1 2 3 4 eye pain/strain
 - 1 2 3 4 excess tearing or dryness
 - 1 2 3 4 blurry vision
 - 1 2 3 4 ear ringing
 - 1 2 3 4 ear pain
 - 1 2 3 4 hearing loss
 - 1 2 3 4 TMJ problems
 - other _____
-

Neurologic

- 1 2 3 4 dizziness / vertigo
- 1 2 3 4 paralysis
- 1 2 3 4 numbness / tingling
- 1 2 3 4 seizures
- 1 2 3 4 balance problems
- 1 2 3 4 muscle weakness
- other _____

Cardiovascular

- 1 2 3 4 palpitations
 - 1 2 3 4 chest pain
 - 1 2 3 4 ankle swelling
 - 1 2 3 4 varicose veins
 - 1 2 3 4 fainting
 - stroke
 - heart murmur
 - heart disease
 - high blood pressure
 - other _____
-

Genito-Urinary

- 1 2 3 4 kidney stones
 - 1 2 3 4 painful urination
 - 1 2 3 4 urinary tract infections
 - 1 2 3 4 frequent urination
 - 1 2 3 4 urinary dribbling
 - 1 2 3 4 blood in urine
 - kidney disease
 - venereal disease _____
 - other _____
-

Endocrine

- 1 2 3 4 feeling hot or cold
- 1 2 3 4 night sweats
- hypoglycemia
- hypothyroid
- hyperthyroid
- Diabetes (type 1 / 2)
- other _____

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Emotional

- 1 2 3 4 mood swings
- 1 2 3 4 nervousness
- 1 2 3 4 nightmares
- 1 2 3 4 feeling low in spirits
- 1 2 3 4 restlessness
- 1 2 3 4 excessive worry
- 1 2 3 4 anxiety
- 1 2 3 4 panic attacks
- 1 2 3 4 contentment
- 1 2 3 4 fulfillment
- 1 2 3 4 have a sense of purpose
- other _____

Other

- 1 2 3 4 anemia
- 1 2 3 4 eczema / hives / rashes
- 1 2 3 4 cold hands / feet
- 1 2 3 4 bruise easily
- 1 2 3 4 extreme thirst
- 1 2 3 4 insomnia
- 1 2 3 4 brittle nails
- 1 2 3 4 hair loss or thinning
- 1 2 3 4 dry skin
- 1 2 3 4 itching _____
- ___ osteoporosis
- ___ cancer _____

Women's Health

- 1 2 3 4 irregular cycles
- 1 2 3 4 heavy periods
- 1 2 3 4 light periods
- 1 2 3 4 bleeding between periods
- 1 2 3 4 vaginal discharge
- 1 2 3 4 nipple discharge
- 1 2 3 4 breast lumps
- 1 2 3 4 breast tenderness
- 1 2 3 4 clotting
- 1 2 3 4 PMS symptoms _____
- _____
- 1 2 3 4 menopausal symptoms _____

- age of first period _____
- age of menopause _____
- # of bleeding days _____
- length of cycle or month _____
- # of pregnancies _____
- # of miscarriages _____
- # of live births _____
- # of abortions _____
- birth control _____
- ___ sexual difficulties _____

Men's Health

- ___ prostate problems
- 1 2 3 4 testicular pain / swelling
- 1 2 3 4 penile discharge
- 1 2 3 4 nipple discharge
- ___ sexual difficulties _____

Right now:

Are you or might you be pregnant? _____ Do you have a pacemaker? _____

Do you have a history of seizures? _____ Fainting? _____

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Lifestyle

What is your daily diet like? _____

What is your work? _____

Do you enjoy your work? Yes / No Why? _____

Do you exercise? Yes / No Type and frequency: _____

Do you sleep well? Yes / No Time to bed: _____ Time to rise: _____

Do you wake rested? Yes / No How many hours of sleep do you get? _____

Do you have someone with whom you can really talk? Yes / No

What in your life promotes your health? _____

What in your life compromises your health? _____

What do you do to relax? _____

How is your home life? _____

Is there any thing else you would like me to know? _____
