

Colleen Gibson Acupuncture LLC

----- Patient Health History -----

All information shared here is kept strictly confidential.

Name _____ Date _____

Age _____ DOB _____ Email _____

Address _____

Phone (home) _____ Phone (cell) _____

OK to leave a message about your care at one or both of the above numbers? Yes/No (if just one circle which)

Emergency Contact _____

Relationship & Phone # _____

Physician _____ Phone # _____

How did you hear about my services? _____

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

1. _____ Date of onset: _____

2. _____ Date of onset: _____

3. _____ Date of onset: _____

How do these concerns affect your daily activities/work/relationships/emotions?

What other types of treatments have you tried? Where they helpful?

_____ Name of practitioner: _____

_____ Name of practitioner: _____

_____ Name of practitioner: _____

What is your present level of commitment to address any underlying causes of your symptoms that relate to your lifestyle? Rate 0-10 where 10 is 100% commitment:

0 1 2 3 4 5 6 7 8 9 10

Lifestyle & Fundamental Aspects of Good Health

Do you sleep well? Y / N Average number of hours of sleep/night _____

Do you exercise or "get out and move" regularly? Y / N List: _____

Do you feel you drink enough water each day? Y / N How much? _____

Do you feel like you have a generally healthy diet? Y / N

Where do you eat out? _____

Do you tend to have cravings? Y / N What are they? _____

Do you consume/use alcohol, caffeine, tobacco or any other drugs /substances? If so, which ones and how much per week? _____

What is your current occupation? _____ How many hours/week: _____

Do you enjoy your work? Y / N What about it? _____

What do you really enjoy doing? _____
 Does your home life support you or add to your stress? _____
 What aspects of your life help you support good health? _____
 What aspects of your life compromise your ability to support good health? _____
 Who do you have in your life that will consistently support and encourage the beneficial lifestyle changes you choose to make? _____

Relevant Medical & Family History

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

Name / Dosage	Reason	For How Long
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please list all major accidents/illnesses/surgeries/hospitalizations and when they occurred.

Please list all Diseases or Conditions that you are currently diagnosed with or believe you may have.

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

Please list any significant family health history (diseases, conditions, tendencies, genetic predispositions, mental health, and premature deaths including age and reason why).

Are you or might you currently be pregnant? Y / N	
Do you have a pacemaker? Y/N	Heart Murmur? Y / N
Do you have a history of seizures? Y / N	Fainting? Y/ N

Chronic Infections, please check all that apply:			
___ HIV	___ Tuberculosis	___ Hepatitis A/B/C	___ STD
	___ AIDS	___ Other: _____	

1 = rarely	2 = occasionally	3 = frequently	4 = always
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If you do not experience the symptom at all, you can leave it unmarked.

Energy, Stress & Mental Function

Rate your energy (low) 1 – 10 (high) _____

Rate your stress (low) 1 – 10 (high) _____

- 1 2 3 4 symptoms are worse with exercise
- 1 2 3 4 symptoms are better with exercise
- 1 2 3 4 symptoms are worse with stress
- 1 2 3 4 body feels generally heavy or weak
- 1 2 3 4 hands & feet feel cold
- 1 2 3 4 “lump in the throat” sensation
- 1 2 3 4 unclear or foggy thinking
- 1 2 3 4 forgetfulness / poor memory
- 1 2 3 4 difficulty concentrating / focusing

Musculo-Skeletal

- 1 2 3 4 muscle tightness/achiness
- 1 2 3 4 muscle spasms / cramping
- 1 2 3 4 frequent sprains or strains
- 1 2 3 4 joint pain / stiffness

Neurological Function

- 1 2 3 4 muscle weakness
- 1 2 3 4 numbness / tingling
- 1 2 3 4 loss of sensation / function
- 1 2 3 4 paralysis
- 1 2 3 4 balance problems

Cardiovascular

- 1 2 3 4 palpitations
- 1 2 3 4 chest tightness or pain
- 1 2 3 4 ankle / lower body swelling
- 1 2 3 4 varicose veins
- 1 2 3 4 high blood pressure
- 1 2 3 4 low blood pressure
- 1 2 3 4 fainting or dizziness
- 1 2 3 4 pale face, nails or inside eyelids
- 1 2 3 4 blackouts / loss of consciousness

Mental & Emotional Tendencies

- 1 2 3 4 feelings of grief / sadness
- 1 2 3 4 feelings of worthlessness
- 1 2 3 4 anxiety / excess worry
- 1 2 3 4 overthinking / rumination
- 1 2 3 4 sense of lack of joy
- 1 2 3 4 excessive happiness / mania
- 1 2 3 4 fear, especially of the unknown
- 1 2 3 4 “depressed” type feelings
- 1 2 3 4 easy to anger / irritability
- 1 2 3 4 indecisiveness
- 1 2 3 4 make time to nurture self
- 1 2 3 4 feel generally positive and capable

Gastro-Intestinal

- 1 2 3 4 poor appetite
 - 1 2 3 4 insatiable appetite
 - 1 2 3 4 unquenchable thirst
 - 1 2 3 4 bitter taste in mouth
 - 1 2 3 4 acid reflux / heartburn
 - 1 2 3 4 general abdominal distention
 - 1 2 3 4 fatigue after meals
 - 1 2 3 4 gas or bloating after meals
 - 1 2 3 4 belching
 - 1 2 3 4 flatulence
 - 1 2 3 4 nausea or vomiting
 - 1 2 3 4 stomach pain (above or below navel?)
 - 1 2 3 4 side or rib pain
 - 1 2 3 4 gall stones
 - 1 2 3 4 intolerance of fatty foods
 - 1 2 3 4 tend towards constipation
 - 1 2 3 4 tend towards loose stools or diarrhea
 - 1 2 3 4 blood in stools
 - 1 2 3 4 mucous in stools
 - 1 2 3 4 undigested food in stools
 - 1 2 3 4 hemorrhoids or prolapse of any kind
- Have you traveled outside of the U.S.? Y / N
- Have you ever had a parasite? Y / N

Head, Eyes, Ears, Nose & Throat

1234 headaches, please describe: _____

- _____
- 1234 dizziness / lightheaded
- 1234 excessive dry or red eyes
- 1234 blurry vision / poor night vision / floaters
- 1234 ear ringing – low or high pitched
- 1234 hearing loss
- 1234 sinus congestion / pressure
- 1234 nasal discharge or congestion
- 1234 nose bleeds
- 1234 dry nose / mouth / throat / eyes
- 1234 chronic sore throat
- 1234 bleeding or swollen gums
- 1234 TMJ problems / jaw pain

Genito-Urinary

- 1234 excess or frequent urination
- 1234 scanty urination
- 1234 waking to urinate at night
- 1234 pain or burning with urination
- 1234 difficulty or inability to pass urine
- 1234 blood in the urine
- 1234 cloudy urine
- 1234 dribbling or incontinence
- 1234 urinary tract or bladder infections
- 1234 kidney stones

Endocrine & Immune Function

- 1234 body tends to feel warm / hot
- 1234 body tends to feel cool / cold
- 1234 hot flashes / feverish sensations
- 1234 chills or aversion to wind/drafts
- 1234 spontaneous day sweats
- 1234 night sweats
- 1234 constant thirst / dry mouth
- 1234 skin problems _____
- 1234 brittle, soft or deformed nails
- 1234 hair loss or thinning
- 1234 unusual hair growth
- 1234 slow wound healing
- 1234 easy bruising
- Where you ever told you were anemic? Y / N

Respiratory

- 1234 catch cold easily (>3x/year)
- 1234 cough (dry or productive)
- 1234 cough up phlegm – color? _____
- 1234 cough up blood
- 1234 shortness of breath or shallow breath
- 1234 sensation of chest constriction
- Do you have asthma? Yes No
- Which is more difficult, inhalation or exhalation?

Men's Health

- 1234 testicular pain / swelling
- 1234 penile discharge
- 1234 low libido
- 1234 sexual difficulties
- Have you had your prostate checked? Y / N

Women's Health

- 1234 vaginal / labial pain or swelling
- 1234 excess vaginal discharge / yeast
- 1234 low libido
- 1234 nipple discharge
- 1234 breast lumps
- monthly self breast exam? Y / N

Menstrual History & Patterns

- Date of last annual exam _____
- Age of first period _____
- Age at Menopause _____
- Is your cycle regular? Y / N
- Do you bleed between periods? Y / N
- # of bleeding days _____
- Total length of cycle (# of days) _____
- Is your bleeding heavy / moderate / light?
- Do you have clots? Y / N
- Do you have cramping? Y / N
- Cramping before / during / after menses?
- Do you have PMS symptoms? Y / N
- Please list: _____

Pregnancy

- # of pregnancies _____
- # of live births _____
- # of miscarriages _____
- # of abortions _____