



Health Assessment

Thank you for choosing Healing Essentials! We are delighted to work with you to restore your body's natural rhythm.

The answers you will provide on these forms and the discussions you will share with your practitioner all add up - like individual pieces of a puzzle - to reveal a larger picture of your health and health concerns. This holistic view allows your concerns to be addressed from both a specific *branch* level and also a deeper *root* level.

Please take time to thoughtfully and honestly answer these questions so that the picture of your health is revealed as clearly as possible.

All information in this questionnaire is confidential.

Name: _____ Today's Date: _____

Address

City: _____ State: _____ Zip: _____

Primary Phone # _____ Secondary Phone _____

E-mail Address

Date of Birth _____ Age _____ Weight _____ Height _____ Sex M / F

Occupation _____

Emergency Contact _____ Phone _____

Have you ever received acupuncture before? If yes, What for?

*Full CASH payment is due on the day of the appointment. Tax is included with treatment prices.
We ask for 24 hour advance notice if you need to cancel an appointment.
You may be charged if you cancel an appointment without 24 hours notice.
Treatments are transferable. Gratuity is accepted.*

Patient ID _____ Rev E 5/09



Medical History

What is your main health concern(s) that brings you in today?

On a scale of 0 -10, 0 = not at all, and 10 = consuming, How do the above affect your daily life? Circle

0 1 2 3 4 5 6 7 8 9 10

Have you been examined by a medical doctor for any of these health concerns?

Yes / No

If yes, what was the diagnosis? _____

Are you currently on medication for this health problem? _____

If Yes, please list: _____

Are you on any medications not related to this problem? _____

List any major surgeries you've had

Significant trauma (accidents, falls)

Have you ever been diagnosed with any of the following: **(Please Circle)**

- Diabetes
- Seizures
- Hepatitis
- Stroke
- Low blood pressure
- Heart Attack
- Substance addiction
- Ulcer/GI bleeding
- Anemia
- Peripheral neuropathy
- Anxiety
- Tuberculosis
- Blood clots
- High blood pressure
- HIV/AIDS
- Arthritis
- Fibromyalgia
- Depression
- Cancer
- Asthma

Patient ID _____ Rev E 5/09



Past medications (current medications will be listed separately on the risk assessment) **(Please Circle)**

- Contraceptives
- Antidepressants
- Pain medication
- Anti-hypertensives
- Long-term antibiotics
- Steroids
- Antacids
- Cholesterol-lowering drugs

Health History

Please circle any symptoms you currently have or have had in the last 3 months.

TEMPERATURE

- Tend to feel hot
- Tend to feel cold
- Hot flashes
- Chills
- Fever
- Alternating chills/fever

PERSPIRATION/THIRST

- Sweat with little exertion
- Night sweats
- Can't sweat
- Thirsty and drink cold
- Thirsty and drink hot
- Thirsty but don't drink
- Not thirsty

ENERGY

- High energy/Jittery
 - Good energy
 - Okay energy/slightly low
 - Low energy/fatigue
 - Hard to get out of bed
- How many times a week do you consume caffeine for energy?
- _____

HEAD

- Migraines
- Headaches
- Dizzy/lightheaded
- Foggy-headedness
- Fainting
- Seizures
- Sinus congestion
- Nasal discharge

SENSES

- Declining vision
- Eyes sensitive to light
- Red/itchy eyes

MOUTH

- Poor teeth
- Frequent sore throats
- Mouth/canker sores



- Floating spots in vision
 - Poor hearing
 - Ear ringing
 - Poor sense of smell
 - Earaches
 - Decreased night vision
 - Lip sores
 - Dry/chapped lips
 - Dry mouth and throat
 - Lump in the throat
 - Swollen/painful gums
 - Taste in mouth, describe (ie bitter)
-

SKIN, HAIR & NAILS

- Thin skin/nails
- Dry skin/nails
- Easily bruised
- Dark under eyes
- Lumps
- Acne
- Abscesses/infection
- Prematurely gray hair
- Hair loss
- Dry/brittle hair

APPETITE

- Excessive appetite
- Poor appetite
- Excessive saliva
- Heartburn/reflux
- Nausea/vomiting
- Tired after eating
- Bad breath

CRAVINGS

- Sweet
- Salty
- Sour

LUNGS & HEART

- Wheezing
- Coughing
- Short of breath
- Tight sensation in chest
- Frequent colds, >2/year
- Seasonal allergies
- Slow heart rate
- Fast heart rate/Irregular rhythm
- Palpitations/fluttering
- Chest pain
- High blood pressure/Low BP

DIGESTION

- Gas, x per wk _____
- Bloating/distention, x per wk _____
- Abdominal pain, x per wk _____
- Stomach pain, x per wk _____
- Gall stones
- Pain under ribs, x per wk _____
- Belching/hiccups, x per wk _____

BOWEL MOVEMENTS

- Constipation
- Loose stool/diarrhea
- Alternating consti/diarh



- Bitter
- Hot/spicy
- Strong flavor/pungent
- Bland
- Crunchy
- Other _____

- Cramps with BM
- Incomplete BM
- Burning with BM
- Hemorrhoids
- Bowel incontinence
- Blood or mucus in stool
- Foul odor

URINATION

- Dark urine
- Cloudy urine
- Burning urination
- Scanty urine
- Profuse urine
- Decreased bladder control
- Frequent urination
- Wake at night 2 or more to urinate
- Frequent UTIs
- Kidney stones

SLEEP

- Insomnia
- Excessive sleep
- Difficulty falling asleep
- Wake during the night
- Lots of vivid dreams
- Disturbing dreams
- Don't get enough sleep
- Wake unrefreshed
- * Hours of sleep each night _____

MENTAL & EMOTIONAL

- Forgetful/poor memory
- Poor concentration
- Irritable/angry
- Sad
- Tearful/weepy
- Restless
- Anxious/worried
- Can't stop thinking
- Fearful/easily startled
- Manic
- Depressed
- Frequent sighing or yawning

DIET & LIFESTYLE

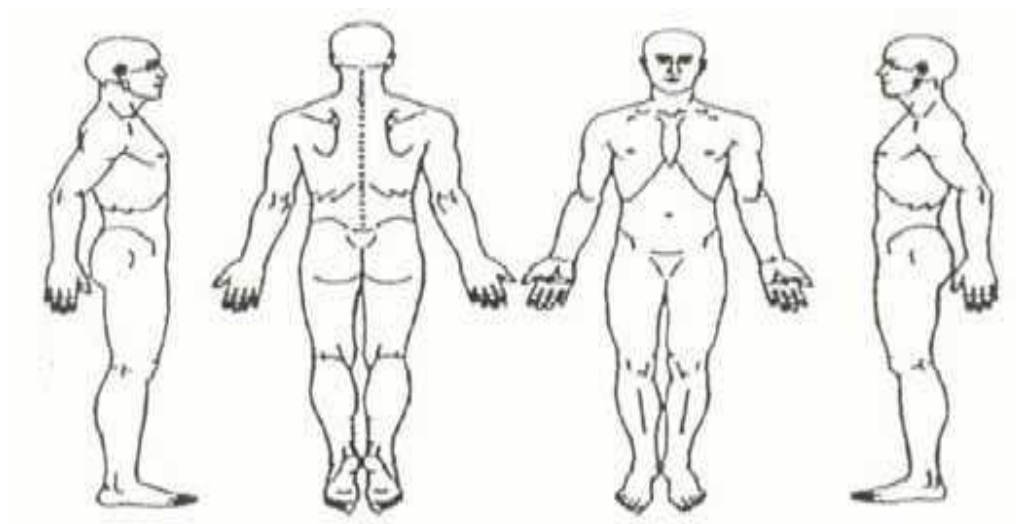
- Poor diet
- Consume caffeine daily
- Smoke cigarettes
- Chew tobacco
- Drink alcohol
- Too little activity/exercise
- Use drugs
- Exercise excessively
- Eating disorder
- Job/Family stress



Healing Essentials
acupuncture

MUSCULOSKELETAL & EXTREMITIES

Mark any areas where you experience pain or numbness



History of: **(Please Circle)**

- TMJ
- Scoliosis
- Joint swelling
- All over body pain
- Muscle tightness
- Cold back or knees
- Weak back or knees
- Body heaviness

Women's Health History **(Please Circle)**

GENERAL GYNECOLOGY

- | | |
|-------------------------------|----------------------------------|
| · High sexual energy (libido) | · Pelvic abnormalities/adhesions |
| · Low sexual energy | · Endometriosis |
| · Chronic vaginal discharge | · Cysts |
| · Regular yeast infections | · Fibroids |
| · Vaginal dryness | · Mastitis |
| · Breast lumps/nodules | · Uterine or bladder prolapsed |
| · PID | · Abnormal pap smear |



Healing Essentials
acupuncture

· STDs

· Others _____

REPRODUCTIVE HISTORY

Are you currently using birth control? Y / N

Are you trying to conceive? Y / N

Are you currently lactating? Y / N

How many pregnancies have you had? _____

How many children do you have? _____

How many abortions have you had? _____

How many miscarriages have you had? _____

Have you had any:

- High-risk pregnancies
- Difficult labor/deliveries
- Postpartum concerns
- Lactation concerns

MENOPAUSE

· Peri-menopausal · Post-menopause since _____

(Please answer menstruation questions to the best of your recollection)

MENSTRUATION

Age when menses began _____

Menstruation lasts _____ days

- Regular cycle: _____ days total
- Irregular: _____ to _____ days

Can you tell when you ovulate? Y / N

During your period, the flow: (note what days of your period, ie day 1, or day 5)

- Light/spotting on days _____
- Medium on days _____
- Heavy on days _____

Patient ID _____ Rev E 5/09



- With clots on days _____
- Spotting between periods

What color is the blood? (note what days of your period, ie day 1, or day 5)

- Light Red on days _____
- Bright Red on days _____
- Dark Red on days _____
- Purple on days _____
- Brown on days _____
- Black on days _____

PMS

- Acne
- Cramps/Backache
- Bowel changes
- Breast changes
- Food cravings
- Irritability/anger
- Nausea
- Sad/Weeping
- Others _____

POST-MENSTRUATION

- Dizziness
- Fatigue
- Insomnia
- Night sweats
- Others _____

Men's Health History
(Please circle)

General Function

- | | |
|--|--|
| <ul style="list-style-type: none"> · Pain with Urination · Low sexual drive · Discharge, if yes, color _____ · Testicular swelling | <ul style="list-style-type: none"> · Erectile Dysfunction · High sexual drive · STD's, if yes, please list:
_____ |
|--|--|

Have you ever been diagnosed with BPH? (Benign Prostrate Hyperplasia) _____

Have you ever had a prostate exam? _____ If yes, when was your last? _____

What is your current PSI rating? _____