

Mountain Sports Acupuncture Patient Health History

Welcome to Mountain Sports Acupuncture, it is our goal to help each patient improve their quality of life and to achieve optimum health. Traditional Chinese medicine offers a unique approach to healing that compliments other health care modalities. We work closely with physicians, alternative practitioners and you, our patient, in order to provide the most thorough treatment.

In order to serve you best we encourage you to fill out this survey in as much detail as possible. Successful health care is only possible when the practitioner has a complete understanding of the patient physically, mentally and emotionally. All symptoms that you experience are relevant and important to us as Traditional Chinese Medicine practitioners. All information will be held in strict confidence. **Thank you.**

Name: _____ Date: ____/____/____
(first) (middle) (last)

Address: _____ City/State: _____ Zip: _____

Telephone#: (H) _____ (C) _____ E-Mail: _____

Emergency Contact (Name /Telephone #): _____

Date of Birth: ____/____/____ Age: _____ Gender: M/F Marital status: S M D W

1. When and where did you last receive health care? _____

For what reason? _____

2. Has your case been referred to an attorney? Y N

3. Please identify the health concerns that have brought you to Mountain Sports Acupuncture in order of importance below:

Condition

Past Treatment

1) _____

How does this condition affect you? _____

2) _____

How does this condition affect you? _____

3) _____

How does this condition affect you? _____

4) _____

How does this condition affect you? _____

4. If applicable, please list any foods, drugs, or medications you are hypersensitive or allergic to (please include reaction):

5. Please list any medications (prescribed and over-the-counter), vitamins, and supplements you are currently taking and their dosage:

6. Do you have any reason to believe you may be pregnant? Y / N If so, how far along are you? _____

7. Do you have any infectious diseases? Y N If yes, please identify: _____

8. **Height:** _____ **Weight:** Currently: _____ Past Maximum: _____ When? _____

9. **Blood Pressure:** What is your most recent blood pressure reading? ____/____/____ When was this reading taken? _____

10. **Childhood Illness:** (Please check any that you have had)

Scarlet Fever
 Diphtheria
 Rheumatic Fever
 Mumps
 Measles
 German Measles
 Chicken Pox

11. **Immunizations** (please check any that you have had):

Polio
 Tetanus
 Measles/Mumps/Rubella
 Pertussis
 Diphtheria
 Hepatitis A & B
 Others: _____

12. **Hospitalizations and Surgeries:**

<u>Reason</u>	<u>When</u>	<u>Reason</u>	<u>When</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

13. **X-Rays/CAT Scans/MRI's/NMR's/Special Studies:**

<u>Reason</u>	<u>When</u>	<u>Reason</u>	<u>When</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

14. Family History:	<u>Father</u>	<u>Mother</u>	<u>Brothers</u>	<u>Sisters</u>	<u>Spouse</u>	<u>Children</u>
<i>Check those applicable:</i>						
Age (if living)	_____	_____	_____	_____	_____	_____
Health (G=Good, P=Poor)	_____	_____	_____	_____	_____	_____
Cancer	_____	_____	_____	_____	_____	_____
Diabetes	_____	_____	_____	_____	_____	_____
Heart Disease	_____	_____	_____	_____	_____	_____
High Blood Pressure	_____	_____	_____	_____	_____	_____
Stroke	_____	_____	_____	_____	_____	_____
Mental Illness	_____	_____	_____	_____	_____	_____
Asthma/Hay fever/Hives	_____	_____	_____	_____	_____	_____
Kidney Disease	_____	_____	_____	_____	_____	_____
Age (at death)	_____	_____	_____	_____	_____	_____
Cause of Death	_____	_____	_____	_____	_____	_____

Below, please CHECK any that you have now, and UNDERLINE any that you have experienced in the past

15. <u>Emotional</u>	<input type="checkbox"/> Eye Pain/Strain	<input type="checkbox"/> TMJ/Jaw Problems	<input type="checkbox"/> Other Respiratory Problems
<input type="checkbox"/> Mood Swings	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Hay Fever	19. <u>Cardiovascular</u>
<input type="checkbox"/> Nervousness	<input type="checkbox"/> Glasses/Contacts	18. <u>Respiratory</u>	<input type="checkbox"/> Heart Disease
<input type="checkbox"/> Mental Tension	<input type="checkbox"/> Tearing/Dryness	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Chest Pain
16. <u>Energy and Immunity</u>	<input type="checkbox"/> Impaired Hearing	<input type="checkbox"/> Frequent Common Cold	<input type="checkbox"/> Swelling of Ankles
<input type="checkbox"/> Fatigue	<input type="checkbox"/> Ear Ringing	<input type="checkbox"/> Difficulty Breathing	<input type="checkbox"/> High Blood Pressure
<input type="checkbox"/> Slow Wound Healing	<input type="checkbox"/> Earaches	<input type="checkbox"/> Emphysema	<input type="checkbox"/> Palpitations/Fluttering
<input type="checkbox"/> Chronic Infections	<input type="checkbox"/> Headaches	<input type="checkbox"/> Persistent Cough	<input type="checkbox"/> Stroke
<input type="checkbox"/> Chronic Fatigue Syndrome	<input type="checkbox"/> Sinus Problems	<input type="checkbox"/> Pleurisy	<input type="checkbox"/> Heart Murmurs
17. <u>Head, Eye, Ear, Nose, & Throat</u>	<input type="checkbox"/> Nose Bleeds	<input type="checkbox"/> Asthma	<input type="checkbox"/> Rheumatic Fever
<input type="checkbox"/> Impaired Vision	<input type="checkbox"/> Frequent Sore Throats	<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Varicose Veins
	<input type="checkbox"/> Teeth Grinding	<input type="checkbox"/> Shortness of Breath	

20. **Gastrointestinal**
- ف Ulcers
 - ف Changes in Appetite
 - ف Nausea/Vomiting
 - ف Epigastric Pain
 - ف Passing Gas
 - ف Heartburn
 - ف Belching
 - ف Gall Bladder Disease
 - ف Liver Disease
 - ف Hepatitis B or C
 - ف Hemorrhoids
 - ف Abdominal Pain
21. **Genito-Urinary Tract**
- ف Kidney Disease
 - ف Painful Urination
 - ف Frequent UTI

- ف Frequent Urination
 - ف Kidney Stones
 - ف Impaired Urination
 - ف Blood in Urine
 - ف Frequent Urination at Night
22. **Female Reproductive/Breasts**
- ف Irregular Cycles
 - ف Breast Lumps/Tenderness
 - ف Nipple Discharge
 - ف Heavy Flow
 - ف Vaginal Discharge
 - ف Premenstrual Problems
 - ف Clotting
 - ف Bleeding Between Cycles
 - ف Menopausal Symptoms
 - ف Difficulty Conceiving
 - ف Painful Periods

23. **Male Reproductive**
- ف Sexual Difficulties
 - ف Prostrate Problems
 - ف Testicular Pain/Swelling
 - ف Penile Discharge
24. **Musculoskeletal**
- ف Neck/Shoulder Pain
 - ف Muscle Spasms/Cramp
 - ف Arm Pain
 - ف Upper Back Pain
 - ف Mid Back Pain
 - ف Low Back Pain
 - ف Leg Pain
 - ف Joint Pain (if so, where?):

25. **Neurological**
- ف Vertigo/Dizziness

- ف Paralysis
 - ف Numbness/Tingling
 - ف Loss of Balance
 - ف Seizures/Epilepsy
26. **Endocrine**
- ف Hypothyroid
 - ف Hypoglycemia
 - ف Hyperthyroid
 - ف Diabetes Mellitus
 - ف Night Sweats
 - ف Feeling Hot or Cold
27. **Other**
- ف Anemia
 - ف Cancer
 - ف Rashes
 - ف Eczema/Hives
 - ف Cold Hands/Feet

28. **Menstrual/Birthing History:**

d. Birth Control Type: _____ e. # of Pregnancies: _____ f. # of Miscarriages: _____ g. # of Abortions: _____

a. Age of First Menses: _____ b. # of Days of Menses: _____ c. Length of Cycle: _____

h. # of Live Births: _____

Is there anything else we should know? _____

29. **Lifestyle:**

- a. Do you typically eat three meals per day? Y N If no, how many? _____
- b. Do you feel you have a healthy diet? Y N
- c. Do you have any particular food cravings? _____
- d. Exercise routine: _____
- e. Spiritual practice: _____
- f. On average, how many hours per night do you sleep? _____ Do you wake rested? Y N
- g. Level of education completed: High School Bachelors Masters Doctorate Other
- h. Occupation: _____ Employer: _____ Hours/Week: _____
- Do you enjoy work? Y/N Why/Why not? _____
- i. Nicotine/Alcohol/Caffeine Use: _____
- j. Have you experienced any major traumas? Y N Explain: _____
- k. How many glasses of non-caffeinated, non-carbonated beverages do you drink per day? _____
- l. Television habits: _____ Reading habits: _____
- m. Interests and hobbies: _____

How did you hear about us? _____