Orenco Acupuncture & Wellness Clinic, LLC

PATIENT HEALTH HISTORY

This Information is Confidential

Please complete the following questionnaire as accurately and thoroughly as possible. The information will be used to manage your care. A complete understanding of the patients health condition is necessary to provide optimal treatment and preventative medicine by the practitioner/clinic.

GENERAL INFORMATION

Full Name:_____ Todays Date:_____/_____/_____

Age:_____ Date of Birth:_____/_____/_____ Gender:(M / F) Height:_____Weight:_____

SSN:_____-_____-_____Marital Status:_____email address:_____

Home Phone:_____ Mobile Phone:_____

Street Address:_____

City:_____State:_____ZIP:_____

Lives with: ____spouse, ____partner, ____children, ____parents, ____friends, ____alone

Emergency Contact:_____ Contact Phone:_____Relationship:_____

Employer:_____Occupation:_____

Work Phone: _____ FAX (work/home):_____

Health Insurance Company:_____Phone:_____

Physician:_____Phone:_____

Are you currently receiving health care? (Y / N) If **Yes**, where and from whom? _____

_____ [circle one]PCP, MD specialist, ND, DC, LAc, LMT, other.

What are the reasons for receiving the above care? _____

If **No**, when and where did you last receive health care? _____

_____For what reason?_____

Do you feel current or prior care for your conditions seen were successful? (Y / N)

What are your expectations in seeking treatment at this clinic? _____

_____

How did you hear about us?_____

Are you pregnant or is there a possibility that you are pregnant? (Y/N)

Do you have any chronic infectious diseases? (Y/N), If yes, please explain:_____

Are you currently suffering from any chronic illness? (Y/N), explain:_____

List any health conditions diagnosed by a Western medicine M.D. _____

HEALTH CONCERNS

What is the primary reason you have come to the clinic?_____

_____

Please list in order of priority the main conditions, symptoms, or concerns you wish to be addressed:

1. _____
2. _____
3. _____

For each condition list the following:

When did it begin?

	Date	What caused it?
1		
2		
3		

What makes it worse or better? Examples: hot or cold bath, sunny or rainy weather, arguments/stress, etc.

	Makes Worse	Makes Better
1		
2		
3		

What does it feel like?

	Examples: dull, achy, sharp, stabbing, tingling, numb, hot, cold, dry, wet, pressure, etc.
1	
2	
3	

Where do you feel it?

	Examples: head, neck, arm, leg, groin, back, abdomen, chest, radiates to (*name area*)
1	
2	
3	

How intense is it? Does it effect your daily life?

	Rate 1 to 10, 10=worst	List how it effects your daily life (ie; interferes with work, exercise, etc.)
1		
2		
3		

When is it at it's worse?

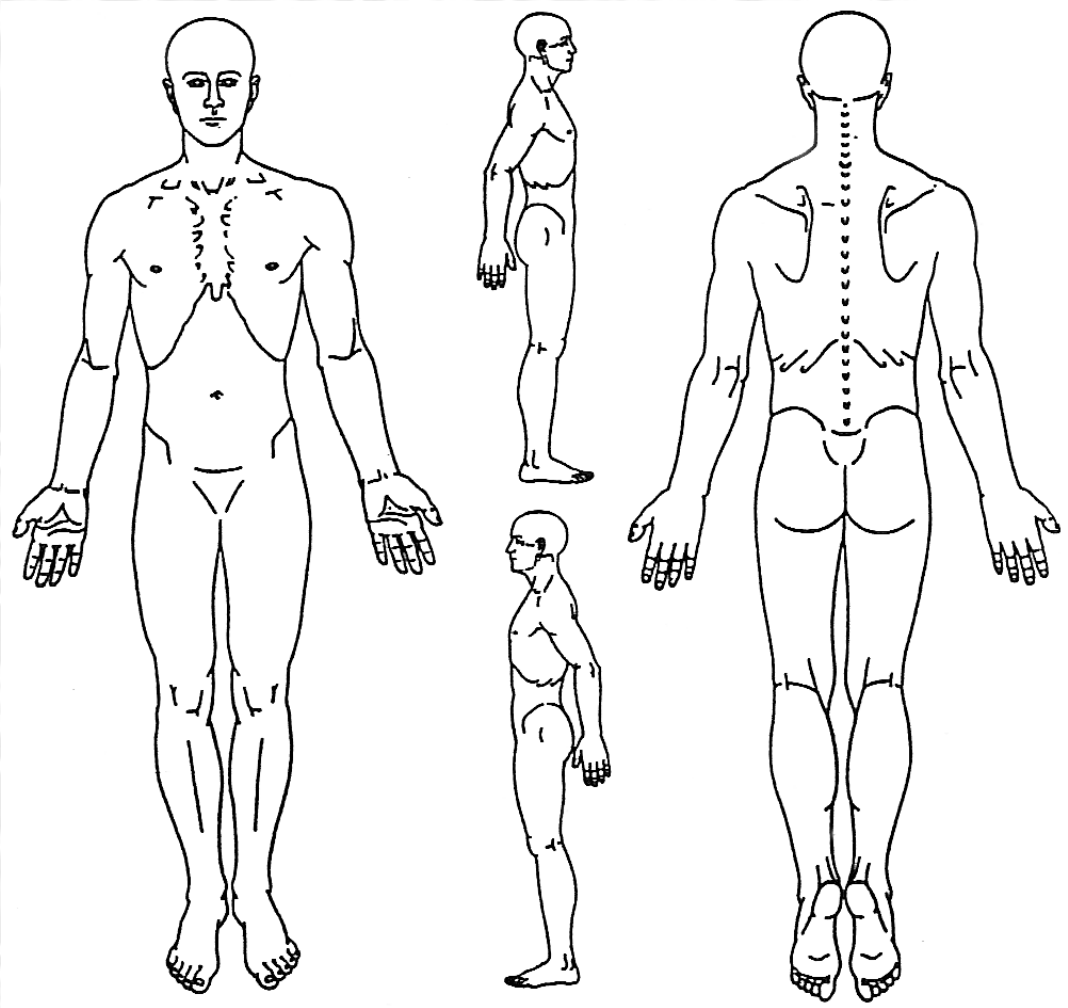
	Examples: night, day, afternoon, morning, winter, summer, after exercise, etc.
1	
2	
3	

Leave This Section Blank

Please list any prescription or over the counter medications, vitamins, supplements, or herbs you are taking and the reason you are taking it:

Medication	**Dosage**	**Duration of Use**	**Reason**

Please circle the area of the body in the diagrams below where you feel pain or other symptoms and number them 1 to 10 to correlate to the level of pain or discomfort. 1=very little pain, 10=worst pain imaginable.



HOSPITALIZATIONS, SURGERIES, ACCIDENTS

Please list any hospitalizations, surgeries, and accidents you've had and their dates.

Date	Describe condition, procedure, or injury.

FAMILY HISTORY

Check all that apply. If you are adopted or have no knowledge of family history check here ☐

Condition	Self	Mother	Father	Grandparents	Siblings	Children
Heart disease						
Cancer						
Diabetes						
Digestive						
Respiratory						
Urinary						
Reproductive						
Thyroid						
Mental Health						
Allergies						
Arthritis						
Anemia						
Stroke						
Thyroid						
Other						

REVIEW OF SYMPTOMS

Please circle any symptoms you have currently and underline any you have had in the past.

General symptoms	
Nervousness, irritability, anxiety	Headaches
Mental tension	Don't sweat enough
Moodiness, depression, melancholy	Sweat too much
Tired, weak, lack of energy	Night sweats
Sleeplessness, sleep too much	Dizziness, convulsions, fainting, seizures
Frequent colds or other illness	Loss or gain of weight
Skin/Hair	
Acne, pimples	Brown spots, browning of skin
Skin rashes, hives	Moles, warts, skin tags
Skin ulcers or sores	Sunburn easily
Flush easily	Cuts heal slowly, scar badly
Hair loss, thinning	Dryness, roughness, scaling
Dry, course hair, split ends	Athlete's Foot, toe fungus
Bruise easily	
Ear Eye Nose Throat	
Near-sightedness, far-sightedness	Spitting up mucus or blood
Blurred, failing vision, night blindness	Hay fever, sinusitis, runny nose
Dryness, burning, itching	Dry mouth or nose, dry or chapped lips
Eyes water excessively	Nosebleeds, bleeding gums
Sensitivity to light, floaters	Sore throats, tonsillitis
Bloodshot, puffy eyes	Clear throat a lot
Earaches	Sore, red, cracked tongue
Noises, ringing in ears	Cold sores, herpes
Ear discharge, excessive wax	Loss of smell or taste
Loss of hearing	Hoarseness
Difficulty breathing	Other:
Shortness of breath on exertion	

Cardiovascular	
Irregular or fast heart beat	blue fingernails
Pacemaker	Leg pains when walking
Chest tightness	varicose veins
Discomfort at high altitudes	Tendency to anemia
Dizziness or weakness on standing	High blood pressure
Swollen feet, ankles or legs	Low blood pressure
Cold hands or feet	Other:
Hands or feet turn blue	
Gastrointestinal	
Loss of appetite	Headache, dizziness, irritability if meals are skipped
Gagging, difficulty swallowing	Diarrhea or loose stools
Nausea, vomiting	Constipation
Bad breath, taste in mouth	Light colored or greasy stools
Food cravings - i.e. sweet, salty, other	Dark stools, blood in stools
Difficulty digesting fats	Undigested food in stools
Heartburn, indigestion or distress	Feeling of incomplete evacuation
Heaviness or fatigue after eating	Foul odor of stool or gas
Gas, belching, bloating	Hemorrhoids, anal fissure
Stomach or abdomen pain	Other:
Symptoms relieved/worsened after eating	Headache, dizziness, irritability if meals are
Sensitivity/avoid certain foods	Diarrhea or loose stools
Urinary	
Difficulty urinating	Blood in urine
Urinate frequently at night	Feeling of heat when urinating
Bed-wetting	Bladder infections
Incomplete urination or dribbling	Kidney infections
Pain when urinating	Kidney stones
Cloudy urine	Other:
Female	
1st Day of Last Period:	Lumps in breasts
Typical # of bleeding days:	Irregular cycles
Typical Length of cycle:	Pain during intercourse
Date of last pap smear:	Diminished or excessive sexual desire
Was it normal?	Difficulty having orgasm
Number of pregnancies:	Painful menses, clotting
Number of live births:	Excessive flow
Number of miscarriages:	Vaginal discharge/dryness
Number of abortions:	Pain, discomfort, itching in genital area
Are you pregnant? Yes No	Use birth control
How many weeks?	Difficulty conceiving
Bleeding between periods	Habitual miscarriages
Depressed, tense, irritability w/ periods	Irregular cycles
Painful or swollen breasts	Pain during intercourse
Discharge from breasts	Menopausal symptoms
Other:	STDs
Male	
Difficult or unusual urination	Swelling or edema of the genitals
Discomfort or pain in genital area	Premature ejaculation
Diminished or excessive sexual desires	Prostate problems
Spontaneous morning erections	Hernias
Difficulty in getting an erection	STDs
Difficulty in maintaining an erection	Other:

Dietary/Lifestyle Patterns	
Coffee/tea/caffeine	Cups a day:
Soda/juices/sweetened drinks	Cups a day:
Alcohol	Drinks per week:
Water	Glasses per day:
Processed/Fast foods	Times a day or week:
Cigarettes or tobacco	Packs a day:
Desserts/sweets	Times per day
Marijuana/other drugs	Times per week:
Exercise	What and how often?
Typical Food Intake	List foods:
Breakfast:	
Lunch:	
Dinner:	
Snacks:	
Drinks:	
Do you have strong desires to any specific food?	
Do you have strong dislikes to any specific food?	
Are there any foods that make you you feel worse?	
Allergies: Please List Each	**How does it affect you?**

Patient Name (print):_____

Patient or Guardian Signature:_____Date:_____