

CLIENT HEALTH HISTORY

The following information will be used by Michael J. Egan, L.Ac. as part of your confidential record. No information contained herein will be released to third parties without your expressed consent. Please let us know if you have concerns about the privacy of your records.

Name: _____

Name you prefer to be called _____

Primary Physician _____ Phone _____

Date of last physical exam _____

Other healthcare providers you see on a regular basis and reason:

_____ Phone _____

_____ Phone _____

_____ Phone _____

Please describe your goals in seeking acupuncture treatment:

Please list any particular questions or concerns you have regarding acupuncture treatment:

Please check the if YOU have been diagnosed with the following.

Please check the if a blood relative has been diagnosed with them.

Alcoholism/Drug Addictions

High Blood Pressure

Asthma/Lung Disease

Hepatitis/Liver Disease

Bleeding Disorders

Kidney Disease

Cancer

Mental Illness

Diabetes

Stroke

Epilepsy/Seizures

Thyroid Disease

Heart Disease

Other _____

Please list any hospitalizations/surgeries and approximate date:

Please list any medications you currently take: _____

Please list all over-the-counter drugs, vitamins, herbs or supplements you currently take: _____

Allergies – medications, foods, and/or environmental?

Please describe any major illnesses, accidents, or traumas:

Please describe your usual physical activity/exercise:

Please give an example of your meals on a typical day:

Breakfast:

Dinner:

Lunch:

Snacks:

How many servings per day do you have of the following?

Coffee _____ Tea _____ Soft Drinks (diet / regular?) _____

Sweets (candy, cookies, donuts, ice cream, etc.) _____

Fast/Fried Food _____ per day / week (please circle)

Cigarettes _____ Other Tobacco _____

Beer/Wine _____ day / week Liquor _____ day / week

Please check any statements that are generally true for you:

- | | |
|---|--|
| <input type="checkbox"/> I feel well rested when I awaken | <input type="checkbox"/> I feel appreciated |
| <input type="checkbox"/> I wake up often during the night | <input type="checkbox"/> I have experienced significant loss |
| <input type="checkbox"/> I have difficulty falling asleep | <input type="checkbox"/> I frequently feel fearful / cautious |
| <input type="checkbox"/> I am aware of lots of dreams | <input type="checkbox"/> I think of myself as powerful |
| <input type="checkbox"/> I am a creative / visionary person | <input type="checkbox"/> I have a good balance between work, family, leisure, and personal time. |
| <input type="checkbox"/> I often feel irritable or angry | <input type="checkbox"/> I am healthier than I used to be |
| <input type="checkbox"/> I have satisfying relationships | <input type="checkbox"/> I am less healthy than I used to be |
| <input type="checkbox"/> I have a good sense of humor | |
| <input type="checkbox"/> I feel well-supported by others | |
| <input type="checkbox"/> I take good care of others | |

Please **check** any of the following symptoms / statements you have **experienced in the past year**. Please **circle** any you are **currently experiencing**, or would particularly like to discuss.

General

- Fatigue
- Fevers
- Night sweats
- Perspiration when not exercising
- Changes in memory
- Changes in mood

Musculoskeletal

- Neck pain
- Jaw Pain (TMJ)
- Arm/shoulder/wrist pain
- Back pain
- Hip pain
- Leg/ankle/foot pain
- Joint Stiffness
- Muscle spasm/stiffness
- Tendon/Ligament problems
- Joint swelling

Skin

- Dry Skin
- Acne/pimples
- Eczema
- Other rashes
- Hives
- Easy bruising
- New or changing moles
- Itching

Head / Eyes / Ears / Nose / Throat

- Dizzy spells/fainting/vertigo
- Frequent headaches
- Severe headaches
- Difficulty with vision
- Red/itchy eyes
- Dry Eyes
- Difficulty hearing
- Ringing in ears
- Nosebleeds
- Sinus infections
- Nasal congestion/ Runny nose
- Mouth/Lip sores
- Bad taste in mouth
- Sore throat
- Hoarseness of voice
- Swollen glands

Cardiovascular

- Irregular heartbeat/palpitations
- Chest pain/tightness
- Pressure in chest
- High blood pressure
- Low blood pressure
- Varicose veins
- Blood clots
- Swelling of feet/ankle
- Cold hands/feet

Respiratory

- Shortness of breath
- Wheezing
- Dry cough
- Wet cough (Phlegm)
- Coughing of blood
- Frequent colds

Gastro-Intestinal

- Difficulty swallowing
- Nausea
- Excessive belching/gas
- Indigestion
- Ulcers
- Abdominal pain
- Constipation
- Diarrhea
- Changes in bowel habits
- Blood in stool
- Hemorrhoids
- Changes in Appetite
- Gained/lost 10lbs in 6 months
- Anorexia/Bulimia

Gastro-Urinary

- Frequency of urination
- Pain or burning with urination
- Leaking of urine/incontinence
- Blood in urine
- Urinate more than 2 times per night
- Bladder/kidney infections
- Sexually active with partner
- Use contraception
- Sexually transmitted diseases

Genito-Urinary Cont'd

For Women:

- Age at first menstrual period
- Date of last menstrual period
- Date of last normal pap smear
- Date of last GYN examination
- Regular menstrual cycle
- Irregular menstrual cycle
- Painful periods
- Heavy bleeding with periods
- Bleeding between periods
- Vaginal Discharge
- Discharge from nipples
- Breast soreness before/with periods
- Bloating before/with periods
- Mood changes before/with periods
- Endometriosis
- Ovarian Cysts
- Infertility
- Changes with breastfeeding
- Uterine prolapse
- Vaginal dryness
- "Hot Flashes"
- Number of pregnancies
- Number of Children
- Generally satisfied with sexual life

For Men:

- Discharge from penis
- Lumps or swelling on testicle
- Infertility
- Number of Children
- Generally satisfied with sexual life

Any other symptoms / experiences you wish to make note of: _____

Signature: _____ Date: _____

Thank you for taking the time to complete this personal health history. It will enable us to better serve your needs and help you meet your goals.

