Elevation Acupuncture & Herbs
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Patient Health History

Name:_____
Last First Middle Initial

Today's Date:_____/_____/_____ Date of Birth:____/____/____

Address:_____

_____

Email:_____

Phone Numbers:(Home)_____(Work)_____(Cell)_____

SS#:_____ Age:_____ Height:_____ Weight:_____

Marital Status: ☐ Married ☐ Single ☐ Partner ☐ Widow ☐ Divorced ☐ Other

Referred By:_____

How did you hear about practitioner?_____

Current or Past Occupation:_____

If Employed, Employer's Name &Phone#_____

_____

Primary Care Doctor's Name, Address, & Phone Number:_____

_____

Emergency Contact:_____

Relationship:_____

Phone:_____

Health Insurance Company:_____

Address:_____

Phone Number:_____

Policy Number_____ Group Number_____

Policy Holder's Name & Date of Birth:_____

Employer that Provides Insurance Name:_____

Plan or Program Name:_____

List any Secondary Insurance:_____

_____

Please List Current Conditions in Order of Importance to You	Describe Symptoms:	List All Treatments Received for this Condition:
Chief Complaint		

Secondary Conditions:		

Attach a separate sheet if you run out of room on the following questions:

List Any Medical Alerts:_____

List Current Medications:_____

_____

List Current Herbs or Supplements:_____

_____

List Types of Exercise & Frequency:_____

_____

List Common Foods Incorporated into Your Diet:_____

_____

List Any Foods You Do Not Eat:_____

Food Allergies:_____

Coffee/Alcohol/Tobacco Intake Per Week:_____

Health Assessment: Please check all that apply

Energy & Sleep: Fatigue Energy fluctuations Hyperactivity Insomnia or interrupted sleep Difficulty waking in morning

Immune System: Frequent colds/flues Slow wound healing Chronic infections Autoimmune Condition: _____

Cardiovascular: High blood pressure Heart Disease Chest Pain Swelling/ Edema Palpitations/flutters High Cholesterol

Respiratory: Asthma Shortness of Breath Persistent Cough History of Pneumonia or Bronchitis Emphysema COPD

Gastrointestinal: Loose stool Constipation Diarrhea Ulcer Diverticulitis Colitis IBS Celiac's Disease Nausea/Vomiting Abdominal pain Passing gas Belching Heart burn/GERD Hemorrhoids Gallbladder disease Liver disease Hepatitis

Urinary-Genital: Frequent urination Painful urination Recurrent UTI Night time urination Urgent urination Incontinence Blood in urine Kidney disease Kidney or Bladder Stones

Emotions: Depression Mood swings Anxiety Stress Mental restlessness Anger Manic episodes

Head, Eyes, Ears, Nose, Throat: ○ Headaches ○ Impaired memory ○ Mental fogginess ○ Blurry vision ○ Glaucoma ○ Glasses/contacts ○ Red/itchy eyes ○ Dry eyes ○ Impaired hearing ○ Ear ringing ○ Sinus problems ○ Hay fever ○ Nose bleeds ○ Frequent sore throats ○ TMJ ○ Teeth grinding

Female Reproductive: ○ Irregular periods ○ Painful periods ○ Heavy flow ○ Scanty flow ○ No menses ○ Menopause ○ PMS ○ Breast lumps/tenderness ○ Vaginal Discharge ○ Difficulty conceiving , List # of days in cycle_____ , # of days of flow_____ , # of Pregnancies_____, # of Live Births_____, Age of first menses_____, Type of birth control:_____

Male Reproductive: ○ Prostate problems ○ Erectile Dysfunction ○ Decreased Libido ○ Testicular pain ○ Other _____

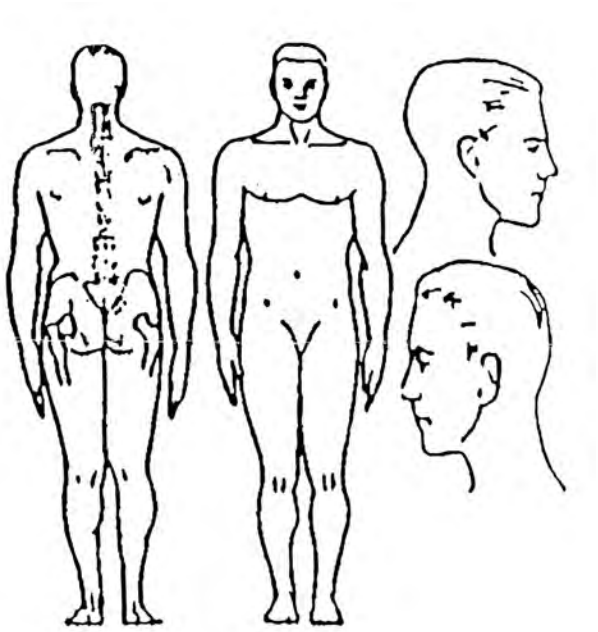
Dermatological: ○ Rashes ○ Eczema ○ Psoriasis ○ Acne ○ Skin Cancer

Endocrine: ○ Hypothyroid ○ Hyperthyroid ○ Hypoglycemia ○ Diabetes Mellitus ○ Night sweats ○ Feeling hot or cold (please circle which)

Neurological: ○ Vertigo/dizziness ○ Paralysis ○ Numbness/tingling ○ Loss of balance ○ Seizures/epilepsy ○ Parkinson's ○ Multiple Sclerosis ○ Tremors ○ Bell's Palsey ○ Trigeminal Neuralgia ○ Other_____

Musculoskeletal: ○ Neck pain ○ Shoulder pain ○ Arm pain ○ Upper back pain ○ Mid back pain ○ Low back pain ○ Leg pain ○ Muscle spasms/cramps ○ Joint Pain ; Where_____

Please describe the nature of your pain & mark with X on the picture:



Medical History: Please includes dates of past conditions or indicate if currently a problem

List All Significant Illnesses, Allergies, Traumas, or Injuries:_____

_____

_____

Hospitalizations & Surgeries:_____

_____

Infectious Diseases:_____

Family History: Check any conditions close blood relatives have had:

☐ Heart Disease ☐ Diabetes ☐ Mental Illness ☐ Thyroid Problems ☐ Cancer

☐ Allergies ☐ Respiratory problems ☐ High Blood Pressure ☐ Stroke ☐

Autoimmune conditions ☐ Other_____

_____

Signature Date