Revival Within
Acupuncture & Wellness

Patient Health Form

Please help us provide you with a complete evaluation by taking the time to fill out this questionnaire carefully. All of your answers will be held absolutely confidential. If you have any questions, please ask.

Date:

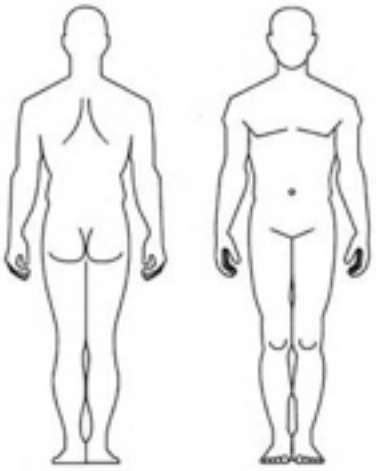
Name(Last)	(First)	(MI)

Current Health History:

Please describe your Chief Complaint(s) (Why you are here today):
How and When did it/they begin?

When did you last receive health care?_____
Diagnosis by an MD?_____
Lab results for the above?_____
Other treatments you have sought_____
What makes it Better?_____Worse?_____

If you are experiencing pain can you put an "X" on the area affected on the image to the right and circle the amount of pain you are feeling on the pain scale listed below, also indicate the area this pain pertains to



1 2 3 4 5 6 7 8 9 10
least pain greatest pain

Please describe the pain as follows: dull, sharp, throbbing, other _____
Does the pain **come and go** or is it **constant**?
Does the pain radiate? **Y / N** If so, where?
_____
Additional description of the pain as needed: _____
_____

Medical History

Allergies (drugs, food, chemical/environmental)
Medications/Supplements/Vitamins

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Surgeries/Procedures (and dates)
Significant injuries/trauma (auto accidents, falls, etc)
Past medical history (including childhood illnesses)

Significant Diagnosis:

__ Blood Disorder/Bleeding Problems __ Diabetes __ Heart Disease __ High Blood Pressure __ Stroke __ Thyroid Problems __ Kidney disease __ Gastrointestinal Problems(Influx, IBD, ulcerative colitis, Crohn's disease __ Respiratory problems __ Cancer (types/dates)	__ Arthritis Rheumatoid/Other _____ __ Hepatitis / Liver disease __ HIV / AIDS __ Tuberculosis __ Sexually transmitted diseases __ Epilepsy / Seizures __ Depression / other mental illness __ Neurological disease (Multiple sclerosis, Parkinson's disease, etc. __ Chemical dependency (alcohol, drugs) __ Other (describe)

Please mark any of the following symptoms that apply to you

General

__Feeling hot/ fevers __Sweats easily __Feeling cold/ chills	__Cravings __Weight gain __Weight loss	__Afternoon / night sweats __Peculiar tastes or smells __Bruise or bleed easily	__Fatigue __Sudden drop in energy __Poor sleep

Skin & Hair

__Eczema __Itching __Dandruff	__Loss of hair __Warts __Pimples	__Rashes/hives __Change in hair or skin texture __Ulcerations/unhealed sores	__Recent moles __Any other hair or skin problems?_____

Head,eyes, ears, nose and throat

__Glasses/contacts __Poor vision __Cataracts __Eye strain __Eye pain __Color blindness __Night blindness __Blurry vision	__Migraines __Headaches(where, when) __Sores on lips, gums,tongue __Loss of smell/ taste __Bitter taste in mouth __Recurrent sore throat __Sneezing	__Sinus problems __Nose bleeds __Facial pain __Jaw clicks/locks __Concussions __Spots/floaters __Poor hearing __Ear aches/pain	__Dizziness __Ringing in ears __Grinding teeth __Gum or teeth problems __Sensation of something stuck in throat __Any other head or neck problems?_____

Respiratory

__Bronchitis __Cough __Asthma __Wheezing	__Pneumonia __Shortness of breath __Coughing blood __Pulmonary embolism	__Pain with a deep breath __Difficult breathing when lying down __Difficulty inhaling/exhaling	__Production of phlegm:loose thick/sticky? What color?____ __Any other lung/breathing problems?

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Cardiovascular

__Chest pain __Irregular heartbeat __High blood pressure __Low blood pressure	__Fainting __Cold hands or feet __Blood clots __Phlebitis	__Swelling of feet/legs __Swelling of hands __Varicose/spider veins	__Peripheral artery disease __Any other heart or blood vessel problems?

Gastrointestinal

__Bad breath __Bleeding gums __Nausea __Vomiting __Gall stones	__Indigestion/acid reflux __Gas __Bloating __Belching __Diarrhea/loose stool	__Constipation __Blood in stools __Black stools __Rectal pain __Hemorrhoids	__Undigested food in stool __Incomplete bowel movements __Abdominal pain or cramps __Any other stomach or intestinal problems?

Urinary

__Frequent urination __Urgent urination __Unable to hold urine __Pain on urination __Blood in urine	__Decrease in urine flow __Kidney stones __Falling (prolapsed) bladder Do you wake up to urinate? Y / N How often?_____	Urine color: light or clear, amber, cloudy, other. (specify): _____ __Any other problems with your urinary system?_____

Male reproductive

__Impotence __Prostatitis __Prostrate cancer __Enlarged prostrate	__Spermatorrhea __Low sperm count __Low motility	__Testicular cancer __Sores on genitals __Testicularpain/ injury	__Premature ejaculation __Any other reproductive problem?_____

Female reproductive

__Are you pregnant? Last Menstrual Period_____ __Is it possible you are pregnant? __Menopause? Age:_____ Age of first menses:_____ Duration of menses_____ Time between menses:_____ Pregnancies? #_____ Live births #_____	Premature births #___ Miscarriages #_____ __Irregular periods __Painful periods __Clots __Vaginal discharge? Color/Smell_____ __Sores on genitals __Infertility	__Western fertility treatments __Breast lumps __Sexually transmitted disease __Menstrual flow (heavy/moderate/light) __Premenstrual symptoms? __Do you practice birth control? Type and for how long?_____ Any other reproductive problems? _____

Musculoskeletal

__Neck pain __Shoulder pain __Hand/wrist pain	__Hip pain __Knee pain __Muscle pain	__Foot/ankle pain __Muscle weakness __Muscle cramping	__Back pain: upper / middle / lower	Any other muscle, joint or bone problems?

Neurological

__Seizures __Vertigo __Dizziness	__Loss of balance __Stroke (when?)____ __Lack of coordination	__Concussion (when?)_____ __Areas of numbness (location) __ __Tremors (where?) _____	__Poor memory __Any other neurological problems?

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Psychological

__Depression __Anxiety __Panic attacks __Easily angered __ADD/ ADHD __Bipolar disorder	__Seasonal affective disorder __Poor concentration __Post-traumatic stress disorder (PTSD) __Easily susceptible to stress __Easily over-worried	__Have you ever been treated for emotional problems?_____ __Have you ever considered or attempted suicide? Any other psychological problems?_____

Dietary History

Do you smoke? **Y / N** how often? _____
Do you drink alcohol? **Y / N** how much & how often? _____
Do you consume caffeine (coffee, soda, tea, supplements)? **Y / N** how often? _____
Do you consume recreational drugs? **Y / N** how often? _____
How much water/fluids do you drink / day? _____ Are you thirsty? **Y / N**
Please describe your average daily diet below

Morning	Noon	Evening	Snacks

Do you regularly miss meals? **Y / N** Eat more than 3 meals/day? **Y / N**
What is you average daily stress level? Please circle below:

1 2 3 4 5 6 7 8 9 10
least greatest

What emotion best describes you? (circle below)
joy(excessive), anger, anxiety, worry/pensiveness, grief/sadness, fear, other:____

Family Medical History:

Please list any medical conditions (some examples listed below) a family member has been diagnosed with and indicate their relationship to you:

*Stroke	*Blood Disorder/Bleeding Problems	*Neurological disease (Multiple sclerosis, Parkinson's disease, etc.)
*Kidney disease	*Arthritis Rheumatoid/Other	
*Diabetes	*Thyroid Problems	
*Hepatitis / Liver disease	*Epilepsy /Seizures	
*Heart Disease	*Depression / mental illness	*Chemical dependency (alcohol, drugs)
*HIV / AIDS	*Gastrointestinal Problems(Influx, IBD, ulcerative colitis, Crohn's disease)	*Cancer (types/dates)
*High Blood Pressure		*Other (describe in chart)
*Tuberculosis	*Respiratory problems	

Maternal	Paternal	Sibling

I certify that the information I have provided above is true and accurate to the best of my knowledge

Signed: (Patient or Legal Guardian)	Date: