LivinBalance Acupuncture and Herbal Medicine LLC

Health History

Date: ____/____/____

Name: _____

Age: _____Date of Birth ____/____/____ Height_____ Weight_____

Living situation (*alone, with spouse, with kids, with roommate(s), other*)_____

Occupation/type of work_____

Occupational concerns (stress, heavy lifting, chemical exposure) _____

Perceived Life Stress (scale 0-10) _____

What would you most like to achieve through your experience with acupuncture/TCM?

_____

How do these conditions impair activities of daily living?_____

_____

How long have you had this condition/these symptoms_____
Diagnoses by a physician_____ date_____
Date of last physical exam_____

If you are experiencing pain, rate your pain level on a scale of 1-10_____
Is the pain

□ sharp	□ cramping	□ fixed
□ burning	□ dull	□ shooting
□ aching	□ moving	□ tingling

Do any of the following improve the pain?

□ pressure	□ heat	□ other
□ cold	□ exercise	

Do any of the following worsen the pain?

□ pressure	□ heat
□ cold	□ other

Hospitalizations, surgeries, significant traumas (physical or emotional)_____
_____

Medical History-check those conditions which apply to you

☐ allergies	☐ fused bones	☐ neck pain
☐ alcoholism	☐ Gallbladder dis.	☐ osteoporosis
☐ anxiety	☐ GI problems	☐ paralysis
☐ arthritis	☐ genetic disorder	☐ pacemaker
☐ asthma	☐ glaucoma	☐ pins, plates, rods
☐ bleeding disorders	☐ headaches	☐ seizures
☐ back issues	☐ hearing problems	☐ sinus issues
☐ blood pressure problems	☐ hepatitis	☐ sexual dysfunction
☐ cancer	☐ infection, chronic	☐ STD's
☐ cardiac problems	☐ jaundice	☐ stroke
☐ cholesterol, elevated	☐ kidney disease	☐ thyroid issues
☐ chronic fatigue	☐ learning disability	☐ tinnitus
☐ circulation problems	☐ liver disease	☐ tumors
☐ depression	☐ mental illness	☐ ulcer
☐ diabetes	☐ meningitis	☐ UTI's
☐ Edema	☐ migraines	☐ varicose veins
☐ emotional problems	☐ multiple sclerosis	☐ vision problems
☐ fibromyalgia	☐ neurologic disorder	☐ weight gain or loss-excessive or sudden

Allergies (drug, chemical, environmental, food, etc.)_____

Parent/siblings significant health history _____
_____

Current/recent medications, supplements, vitamins_____

_____

_____

Typical Diet
Breakfast _____

Lunch _____

Dinner_____

Snacks_____

Beverages _____
Alcohol per week_____

Typical Exercise: Days per week_____ Length of workout_____
Type of Activity _____