Lorene Harris, L.Ac.

Bodywise Acupuncture & Traditional Medicinals Clinic

Health History Intake

Welcome to the world of Acupuncture and Traditional Chinese medicine. In order to serve you in the best possible way, I need to be informed of your complete health history and updates. Please complete this form as thoroughly as possible. If something is not clear, indicate with a question mark. All information is held in confidence. Thank You.

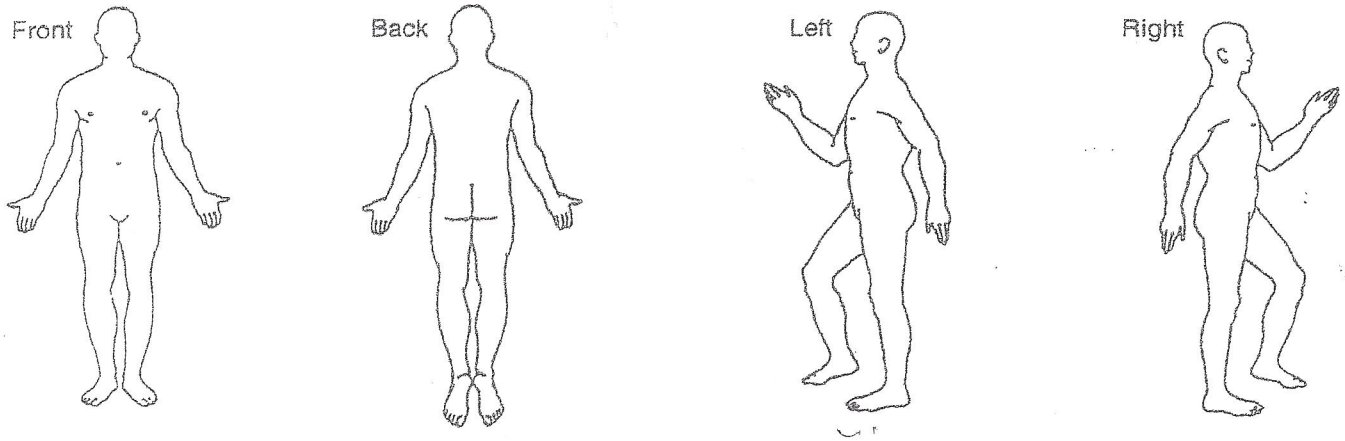
Personal Information

Todays Date_____
Name_____ Phone_____
Address_____ Other Phone_____
City_____ State_____ Zip_____
Email_____ May I contact email?_____
How will you pay?_____
Date of Birth_____ Height_____ Weight_____
Occupation_____
Satisfaction with work:_____
Spouse/partner name _____ No. of children_____ Ages:_____
Emergency Contact name:_____ Phone_____
Current Health Professional_____
Have you ever had Acupuncture/Herbal Medicine/Shiatsu or Tui na?
How did you here about this practitioner?_____

Current Condition
Primary reason for today's visit?_____
_____
_____
_____
How long have you had this condition?_____
Is it getting worse?_____ Does it interfere with work?_____Sleep?_____Other?_____
What is the initial cause?_____
What makes it worse?_____
What makes it better?_____
Have you been given a diagnosis for this condition? Yes No If so, what and by whom?
_____
What treatments have you tried?
_____
What medications are you currently taking? (prescription drugs, herbs, vitamins, etc.)

Date began	Drug/vitamin/supplement	Dose
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Mark area of Pain



Please circle what applies to you.

1 - Never 2 - Rarely 3 - Occasionally 4 - Frequently 5 - Always

1	2	3	4	5	low appetite	1	2	3	4	5	ravenous appetite
1	2	3	4	5	loose stools	1	2	3	4	5	heartburn/acid reflux
1	2	3	4	5	mouth sores	1	2	3	4	5	fatigue after eating
1	2	3	4	5	gas/bloating after food	1	2	3	4	5	bruise easily
1	2	3	4	5	bleeding/swollen gums	1	2	3	4	5	thirst
1	2	3	4	5	organ prolapsed (diagnosed)	1	2	3	4	5	belching or vomiting
1	2	3	4	5	allergies	1	2	3	4	5	catch colds easily
1	2	3	4	5	asthma	1	2	3	4	5	shortness of breath
1	2	3	4	5	general weakness	1	2	3	4	5	cough
1	2	3	4	5	dry nose/mouth/skin/throat	1	2	3	4	5	nasal discharge
1	2	3	4	5	feel worse after exercise	1	2	3	4	5	sinus congestion
1	2	3	4	5	sore, cold or weak knees	1	2	3	4	5	feel cold, in core
1	2	3	4	5	low back pain	1	2	3	4	5	cold hands &/or feet
1	2	3	4	5	frequent urination	1	2	3	4	5	urinary incontinence
1	2	3	4	5	early morning diarrhea	1	2	3	4	5	hearing loss
1	2	3	4	5	impaired memory	1	2	3	4	5	edema
Normal		*High*		*Low*	libido / sex drive			❑ YES		❑ NO	hair loss
1	2	3	4	5	muscle spasms/twitches	1	2	3	4	5	irritable
1	2	3	4	5	feel better after exercise	1	2	3	4	5	numb extremities
1	2	3	4	5	tightness in chest	1	2	3	4	5	dry eyes
1	2	3	4	5	alternating diarrhea & constipation	1	2	3	4	5	ear ringing
1	2	3	4	5	symptoms worse with stress	1	2	3	4	5	anger easily
1	2	3	4	5	neck/shoulder tension	1	2	3	4	5	red eyes
1	2	3	4	5	feel heart beating	1	2	3	4	5	chest pain
1	2	3	4	5	insomnia	1	2	3	4	5	disturbing dreams
1	2	3	4	5	sores on tip of tongue	1	2	3	4	5	headaches
1	2	3	4	5	chest pain traveling to shoulders	1	2	3	4	5	restlessness
Normal		*High*		*Low*	overall body temperature	1	2	3	4	5	anxiety
Normal		*High*		*Low*	overall energy level	1	2	3	4	5	panic attacks
1	2	3	4	5	see floaters in eyes	1	2	3	4	5	foggy thinking
1	2	3	4	5	heat in palms or soles	1	2	3	4	5	dizzy upon standing
1	2	3	4	5	feeling of heaviness	1	2	3	4	5	nausea
1	2	3	4	5	afternoon fever	1	2	3	4	5	night sweats
1	2	3	4	5	enlarged lymph nodes	1	2	3	4	5	cloudy urine
1	2	3	4	5	face flushes						

Secondary Complaints

Please list any other health concerns or conditions:

Past Medical history

Please check all that apply and give dates

Cancer_____ Asthma_____ Pneumonia_____
Diabetes_____ Heart Disease_____ HIV/AIDS_____
Hepatitis_____ Rheumatic Fever_____ Drug/Alcohol Addiction_____
High/Low Blood Pressure___ Thyroid Disease_____ Frequent Colds/Flus_____
Rate_____ Seizures_____ Bronchitis_____
Allergies(describe)_____
Other (describe)_____

Surgeries, serious illness, physical traumas

Date Describe

_____ _____
_____ _____
_____ _____
_____ _____

Emotional Trauma

Date Describe

_____ _____
_____ _____
_____ _____

Please List any major diseases, illnesses, deaths and their causes of family members:

Date Describe

_____ _____
_____ _____
_____ _____

Lifestyle

Please check all that apply and describe:

Tobacco use_____ Therapy/Counseling_____
Alcohol_____ Exercise_____
Coffee/Tea_____ Meditation_____
Soft drinks_____ Stress_____
Laxatives_____ Occupational hazard_____
Aspirin or Pain Medication_____ Other_____

General Health

Please **Check** or **Circle** all that apply

Appetite: Low___ Normal____ High_____

Diet: Standard_____ No red meat___ Lacto-vegetarian_____Vegetarian____Vegan__Other___

Taste craving: Sweet _____Salty_____Spicy_____Bitter_____Sour_____ No Craving_____

Tend to feel Cold_____Hot_____Normal_____All over_____Extremities Only_____

Emotion: Fear_____Joy_____Anger_____Grief/Sadness_____Worry/Guilt/Obsessing_____

Other_____

Heavy Sleep	Fever	Bleed/bruise easily	Lymphatic swelling
Falling asleep	Chills	Weight loss	Varicose Veins
Staying asleep	Night Sweats	Weight gain	Prefer cold drinks
Disturbing sleep	Sweat easily	Peculiar Smell/Taste	Prefer hot drinks
Fatigue	Tremors	Edema	Sudden Energy drop

Musculoskeletal

Neck Pain	Hip Pain	Hand/WristPain	Swollen Joints
Shoulder Pain	Knee Pain	General Muscle Pain	Numbness
Back Pain	Foot/Ankle Pain	Muscle Weakness	Tremors

Cardiovascular

Heart Palpitations	Irregular Heartbeat	Blood Clots	Cold Hands/Feet
Chest Pain	Fainting	Swelling of Hands/Feet	Hot Hands/Feet

Respiratory

Difficulty Breathing	Tight Chest	Cough	Pneumonia
Shortness of Breath	Weak Voice	Congestion	Frequent Infections

Gastrointestinal

Nausea	Belching	Hemorrhoids	Disinterest in Eating
Vomiting	Hiccups	Stomach Acid	Abdominal Pain/Cramps
Diarrhea/Constipation	Indigestion	Low Body Weight	Abdominal Bloating
Gas	bad Breath	Frequent Desire to eat	Gurgling in Stomach

Neurological, Psychological

Seizures	Lack of Coordination	Anxiety	Indecisive
Dizziness	Poor Memory	Irritable	Fearful
Loss of Balance	Concussion	Have Anger	Easily Stressed
Areas of Numbness	Depression	LoseTemper Easily	Thoughts of Suicide

Head, Eyes, Ears, Nose, Throat

Wear Glasses	Eye Strain	Ringing in the Ears	Facial Pain
Night Blindness	Eye Pain	Poor Hearing	Sores on Lips/Mouth
Color Blindness	Dry Eyes	Sinus Problems	Teeth Problems
Cataracts	Migraines	Nose Bleeds	Jaw Clicks
Spots in front of eyes	Headaches	Reoccurring Sore throat	Dry Mouth
Blurry Vision	Ear Aches	Grinding Teeth	Excessive Saliva

Skin and Hair

Dry Skin & Hair	Oily Skin/Hair	Skin Rash	Psoriasis
Dandruff	Acne/Pimples	Itching	Recent Moles
Loss of Hair	Open Sores on Skin	Eczema	Cysts/Tumors

GenitoUrinary

Frequent Urination	Painful Urination	Unable to Hold Urine	STDs_____
Waking Up to Urinate	Decrease in Urination	Blood in Urine	Reduced Sex Drive

Women

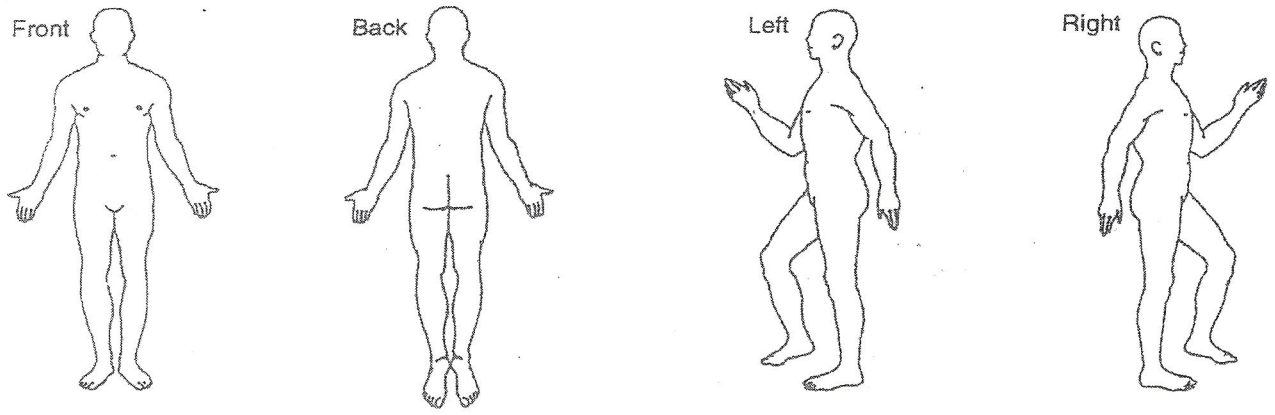
Age of First Menses__	Blood Clots	Peri-Menopausal	Miscarriages #____
Heavy Menses__days	Ovarian Cysts	Menopause at Age__	Abortions #_____
Light Menses__days	Yeast Infections	Pregnancies #___	Currently Pregnant
Irregular Menses	Endometriosis	Live Birth #_____	# of Month_____
Painful Menses	Infertility	Premature Birth #___	
PMS____days	Hysterectomy	C-Section Deliveries	

Men

Erectile Dysfunction	Premature Ejaculation	Painful/Swollen Testicles	Painful Ejaculation
Prostatitis	Nocturnal Emissions	Performance Anxiety	

Areas of Pain

Please mark all painful areas



Additional Comments

Please provide any additional important information which has not already been covered above: