

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

Form fields for personal information including: Today's 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

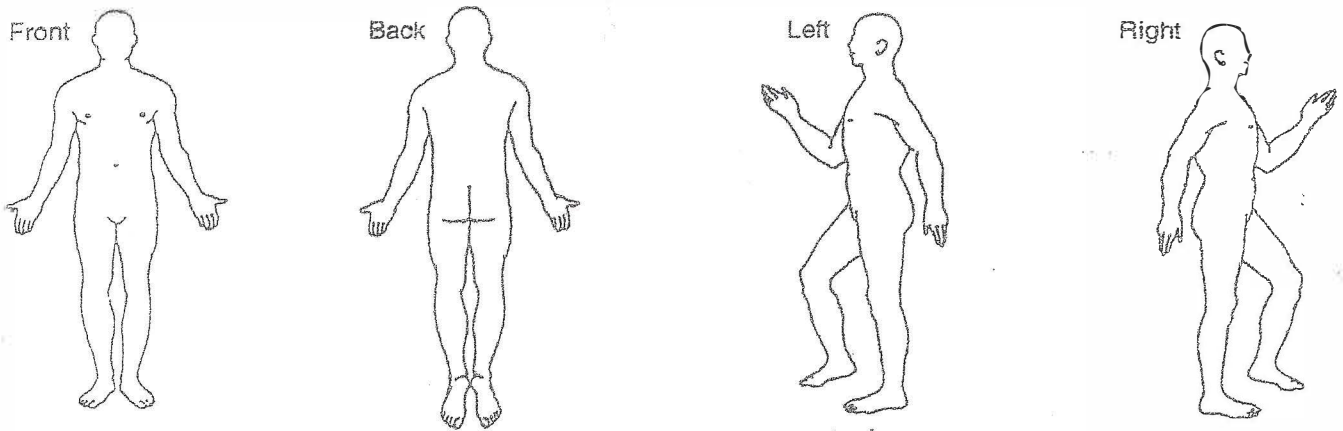
Primary reason for today's visit?

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?

Table with 3 columns: Date began, Drug/vitamin/supplement, Dose. Contains multiple rows for medication tracking.

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							<input type="checkbox"/> YES <input type="checkbox"/> 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/Wrist Pain	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	Lose Temper 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 Waking Up to Urinate	Painful Urination Decrease in Urination	Unable to Hold Urine Blood in Urine	STDs_____ Reduced Sex Drive
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Women

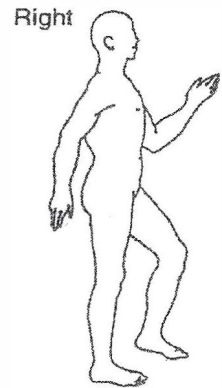
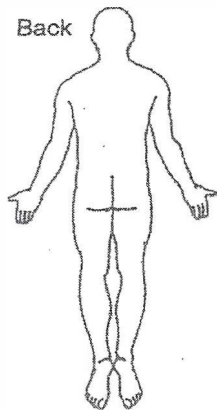
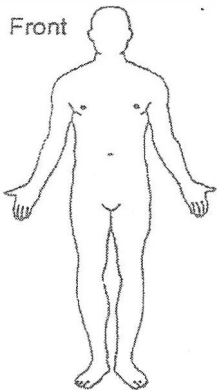
Age of First Menses__ Heavy Menses__days Light Menses__days Irregular Menses Painful Menses PMS____days	Blood Clots Ovarian Cysts Yeast Infections Endometriosis Infertility Hysterectomy	Peri-Menopausal Menopause at Age__ Pregnancies #__ Live Birth #_____ Premature Birth #__ C-Section Deliveries	Miscarriages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

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

Please mark all painful areas



Additional Comments

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



**Payment Information & Agreement
Massage and Acupuncture**

Patient Name _____ Date _____

Cancellation and Missed Appointment Policy

We kindly ask that you provide **at least 24 hours' notice** for any cancellation or rescheduling of massage or acupuncture appointments.

Appointments that are **missed or canceled with less than 24 hours' notice** will incur at **\$50 fee**. If a **credit card is on file**, the fee will be automatically charged. If **no card is on file**, you are still responsible for the fee and **prompt payment is expected**.

This policy is in place out of respect for our therapists' time and to allow other patients the opportunity to be seen. We appreciate your understanding.

By signing below, I acknowledge that I have read and understand the above policy, and I agree to pay the \$50 fee in accordance with this cancellation policy, whether or not a card is on file.

Patient Initials

Credit Card on File Authorization

Card Number _____

Expiration Date _____ Security Code _____ Zip Code _____

While keeping a credit card on file is **not required**, it is **highly encouraged** for your convenience. Please indicate your preferred method of handling charges:

- Please charge my card for any and all charges.**

I authorize automatic charges to my card on file for all services rendered.

- Do not charge my card on file.**

I understand I am responsible for all balance and will pay by another method upon receiving a statement.

Patient Initials