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HEALTH HISTORY INTAKE

Personal & Work Information

Patient Name:____ Date: _______________

Address:___________________________ City:__________________ State: ____ Zip: _________

Home Phone: _______________ Cell Phone: _______________ Work Phone: _______________
Email:____
Birthdate:____/_____/_____ Sex: □ M □ F
□ Married □ Partner □ Single □ Separated □ Divorce □ Widowed

Occupation:_____________________________ Employed By: ___________________________

How did you learn about my practice? □ Friend □ Internet □ Health Professional □ Other

Records Release & Assignment of Insurance Benefits

The undersigned hereby authorizes the release of any information relating to claims for benefits submitted. I further agree and authorize Peggy Johnston L.Ac. to submit claims for benefits, for services rendered, without obtaining my signature on each claim.

I (patient) ___________________________ hereby authorize (insurance company) ______________ to pay and hereby assign directly to Peggy Johnston L.Ac. all owed benefits. I understand that I am financially responsible for all charges incurred, whether or not they are covered by my insurance company. This authorization shall remain valid until written notice is given by me revoking said authorization.

Signature of Patient: ________________________________ Date: _________________________

Health History

Primary complaint: ____

History of Present Illness:

Where does it hurt? ____

How long have you had this problem? ____

What does it feel like when it hurts? ____

Does the pain/problem occur at a specific time? ____

What other associated problems have you been having? ____

What makes the pain/problem worse or better? ____

Previous Hospitalizations/Surgeries/Serious Illnesses:

	When?	Hospital, City, State

Medications (include non-prescription, vitamins, supplements, etc) ____

____

Family Medical History

Relation	Age	Diseases	If deceased, cause of death

Please mark an "X" next to any conditions you have had in the past and a "√"after conditions you currently have:

MENTAL/EMOTIONAL
___Mood swings/depression
___Eating disorder
___History of counseling
___Tension
___Anxiety or nervousness
___Considered/attempted suicide
___Seasonal depression

ENDOCRINE
___Thyroid problems
___Heat or cold intolerance
___Fatigue
___Hypoglycemia
___Excess thirst or hunger
___Diabetes

IMMUNE
___Chronic fatigue syndrome
___Chronically swollen glands
___Chronic infections
___Frequent colds
___Autoimmune disease
___Allergies

NEUROLOGIC
___Seizures
___Vertigo or dizziness
___Paralysis
___Muscle weakness
___Numbness or tingling
___Loss of balance
___Loss of memory

SKIN
___Rashes
___Color change
___Eczema
___Fungus
___Itching
___Acne or boils

HEAD
____Headaches
____Migraines
____Head injury
____Jaw/TMJ problems

RESPIRATORY
___Cough
___Pain on breathing
___Wheezing or asthma
___Shortness of breath
___Bronchitis
___Spitting up blood

NOSE AND SINUS
___Stuffiness
___Nose bleeds
___Hay fever
___Sinus problems
___Loss of smell
___Sinus headaches

EARS
___Impaired hearing
___Earaches
___Ringing

MOUTH AND THROAT
___Teeth grinding
___Hoarseness
___Copious saliva
___Dry mouth
___Gum problems
___Sore tongue or lips
___Frequent sore throat
___Mouth sores

EYES
___Floaters or 'spots'
___Cataracts
___Blurriness
___Double vision
___Glaucoma
___Near/far sightedness
___Tearing or dryness
___Eye pain/strain
___Impaired vision

MUSCULOSKELETAL
___Joint pain
___Joint stiffness
___Arthritis
___Weakness
___Sciatica
___Broken bones
___Muscle pain
___Muscle spasm
___Osteoporosis

URINARY/KIDNEY
___Pain on urination
___Increased frequency
___Frequency at night
___Kidney stones
___Infections
___Urine leakage

CARDIOVASCULAR
___Heart disease
___Murmurs
___Chest pain
___Poor circulation
___Blood clots
___Deep leg pain
___Valvular problems
___Palpitations
___Easy bruising
___Anemia
___Varicose veins
___Fainting
___Swelling in ankles

REPRODUCTIVE
___Pain with intercourse
___Chlamydia
___Herpes
___Genital warts
___Discharges or sores
___Sexual difficulties
___Trouble conceiving

GASTROINTESTINAL
___Trouble swallowing
___Nausea
___Vomiting
___Diarrhea
___Belching
___Passing gas
___Change in appetite
___Heartburn
___Ulcer
___Change in thirst
___Hemorrhoids
___Pain or cramps
___Black stool
___Blood in toilet

FEMALE ONLY
___# days of bleeding per cycle?
___Are cycles regular?
___PMS
___Length of cycle (days)
___Bleeding between cycles
___Discharge
___Painful menses
___Endometrioses
___Menopause symptoms
___Breast lumps or pain
___Nipple discharge
___Do you do self breast exams? y/n
___Age of first menses
___Clotting
___Heavy cycles
___Abnormal paps
___Ovarian cysts
___# of pregnancies
___# of miscarriages
___# of live births
___# of abortions
When was last period? __________

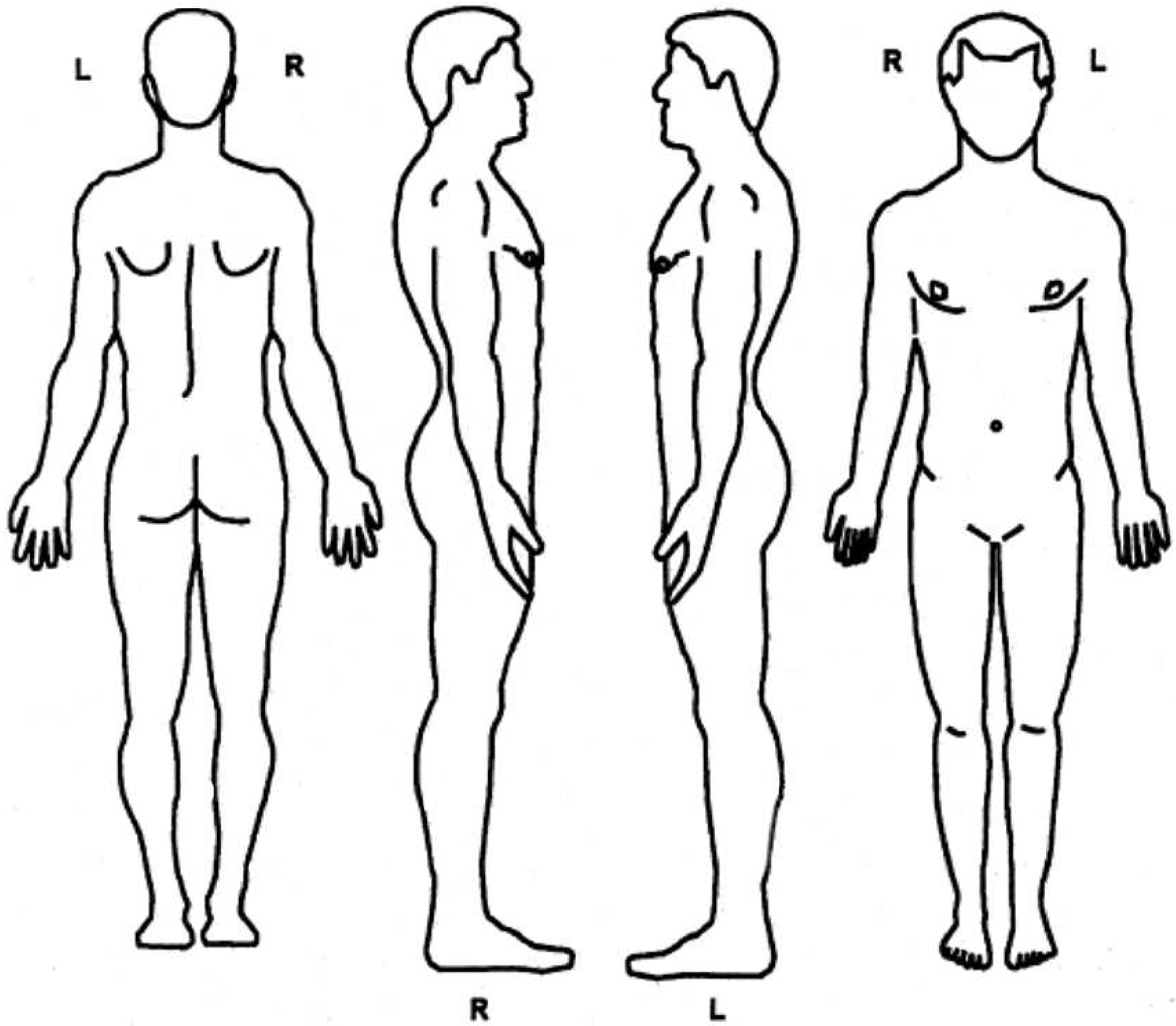
MALE ONLY
___Hernias
___Testicular mass
___Prostate disease
___Impotence
___Testicular pain
___Premature ejaculation

HABITS
Do you exercise? ________ If yes, what kind and how often? ____

____
Do you have a spiritual practice? ________ If yes, what kind? ____
How many hours do you sleep? ________ Do you sleep well? ________ Use recreational drugs?___________
Drink coffee? _________ Drink cola? __________ Eat 3 meals a day? __________
Use tobacco? _________ Consume alcohol? ________ How much water do you drink daily? _____________
Food intolerances (if known):____
How does your health condition affect your life on an ongoing basis? ______________________________
____
How would your life be different if you didn't have this condition? ______________________________
____
On a scale of 1-10, how committed are you to improving your state of health? ____________
On a scale of 1-10, how much change are you willing to make at this time for improvement? __________

PAIN DRAWING

Name:____ Date ______________________



Mark as follows:

A = Ache B = Burning N = Numbness P = Pins & Needles

S = Stabbing O = Other – Describe ____