

# Inner Gate Acupuncture and Herbal Clinic

## Patient Health History

**Welcome to our Clinic.** At Inner Gate Acupuncture & Herbal Clinic it is our goal to help each patient improve their quality of life and to achieve optimum health. Traditional Chinese medicine, which consists primarily of Acupuncture and Chinese Herbs, offers a unique approach to healing that nicely compliments other health care modalities. We work closely with physicians, alternative practitioners and you, our patient, in order to provide the best and most thorough treatment.

In order to serve you best we encourage you to fill out this survey in as much detail as possible. Successful health care is only possible when the practitioner has a complete understanding of the patient physically, mentally and emotionally. All symptoms that you are experience are relevant and important to us as Chinese Medicine practitioners. All information will be held in strict confidence. **Thank you.**

Name: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
(first) (middle) (last)

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Social Security Number: \_\_\_\_-\_\_\_\_-\_\_\_\_ Age: \_\_\_\_ Gender: \_\_\_\_ Marital status: S M D W P

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_ Zip: \_\_\_\_\_

Phone Number: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Email Address: \_\_\_\_\_

1. When and where did you last receive health care? \_\_\_\_\_  
For what reason? \_\_\_\_\_

2. Has your case been referred to an attorney? Y N

3. Please identify the health concerns that have brought you to our clinic in order of importance below:

### Condition

### Past Treatment

- 1) \_\_\_\_\_  
How does this condition affect you? \_\_\_\_\_
- 2) \_\_\_\_\_  
How does this condition affect you? \_\_\_\_\_
- 3) \_\_\_\_\_  
How does this condition affect you? \_\_\_\_\_
- 4) \_\_\_\_\_  
How does this condition affect you? \_\_\_\_\_

4. If applicable, please list any foods, drugs, or medications you are hypersensitive or allergic to (please include reaction):  
\_\_\_\_\_

5. Please list any medications (prescribed and over-the-counter), vitamins, and supplements you are currently taking:  
\_\_\_\_\_  
\_\_\_\_\_

6. Do you have any reason to believe you may be pregnant? Y / N If so, how far along are you? \_\_\_\_\_

7. Do you have any infectious diseases? Y N If yes, please identify: \_\_\_\_\_

8. **Height:** \_\_\_\_\_ **Weight:** Currently: \_\_\_\_\_ Past Maximum: \_\_\_\_\_ When? \_\_\_\_\_

9. **Blood Pressure:** What is your most recent blood pressure reading? \_\_\_\_/\_\_\_\_ When was this reading taken? \_\_\_\_\_

10. **Childhood Illness:** (Please check any that you have had)

\_Scarlet Fever \_Diphtheria \_Rheumatic Fever \_Mumps \_Measles \_German Measles \_Chicken Pox

11. **Immunizations** (please check any that you have had):

\_Polio \_Tetanus \_Measles/Mumps/Rubella \_Pertussis \_Diphtheria \_Hepatitis A & B \_Others: \_\_\_\_\_

**12. Hospitalizations and Surgeries:**

<u>Reason</u>	<u>When</u>	<u>Reason</u>	<u>When</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**13. X-Rays/CAT Scans/MRI's/NMR's/Special Studies:**

<u>Reason</u>	<u>When</u>	<u>Reason</u>	<u>When</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**14. Family History:**

*Check those applicable:*

	<u>Father</u>	<u>Mother</u>	<u>Brothers</u>	<u>Sisters</u>	<u>Spouse</u>	<u>Children</u>
Age (if living)	_____	_____	_____	_____	_____	_____
Health (G=Good, P=Poor)	_____	_____	_____	_____	_____	_____
Cancer	_____	_____	_____	_____	_____	_____
Diabetes	_____	_____	_____	_____	_____	_____
Heart Disease	_____	_____	_____	_____	_____	_____
High Blood Pressure	_____	_____	_____	_____	_____	_____
Stroke	_____	_____	_____	_____	_____	_____
Mental Illness	_____	_____	_____	_____	_____	_____
Asthma/Hay fever/Hives	_____	_____	_____	_____	_____	_____
Kidney Disease	_____	_____	_____	_____	_____	_____
Age (at death)	_____	_____	_____	_____	_____	_____
Cause of Death	_____	_____	_____	_____	_____	_____

**15. Lifestyle:**

- a. Do you typically eat at least three meals per day?      Y   N      If no, how many? \_\_\_\_\_
- b. Do you feel you have a healthy diet?      Y   N
- c. Do you have any particular food cravings? \_\_\_\_\_
- d. Exercise routine: \_\_\_\_\_
- e. Spiritual practice: \_\_\_\_\_
- f. How many hours per night do you sleep? \_\_\_\_\_      Do you wake rested?      Y      N
- g. Level of education completed:      High School      Bachelors      Masters      Doctorate      Other
- h. Occupation: \_\_\_\_\_      Employer: \_\_\_\_\_      Hours/Week: \_\_\_\_\_  
Do you enjoy work?      Y/N      Why/Why not? \_\_\_\_\_
- i. Nicotine/Alcohol/Caffeine Use: \_\_\_\_\_
- j. Have you experienced any major traumas?      Y      N      Explain: \_\_\_\_\_  
\_\_\_\_\_
- k. How many glasses of non-caffeinated, non-carbonated beverages do you drink per day? \_\_\_\_\_
- l. Television habits: \_\_\_\_\_      Reading habits: \_\_\_\_\_
- m. Interests and hobbies: \_\_\_\_\_

*Below, please CHECK any that you have now, and UNDERLINE any that you have experienced in the past*

16. **Respiratory**

- Pneumonia
- Frequent Common Cold
- Difficulty Breathing
- Emphysema
- Persistent Cough
- Pleurisy
- Asthma
- Tuberculosis
- Shortness of Breath
- Other Respiratory Problems

17. **Head, Eye, Ear, Nose, & Throat**

- Impaired Vision
- Eye Pain/Strain
- Glaucoma
- Glasses/Contacts
- Tearing/Dryness
- Impaired Hearing
- Ear Ringing
- Earaches
- Headaches
- Sinus Problems
- Nose Bleeds
- Frequent Sore Throats
- Teeth Grinding
- TMJ/Jaw Problems
- Hay Fever

18. **Neurological**

- Vertigo/Dizziness

- Paralysis
- Numbness/Tingling
- Loss of Balance
- Seizures/Epilepsy

19. **Energy and Immunity**

- Fatigue
- Slow Wound Healing
- Chronic Infections
- Chronic Fatigue Syndrome

20. **Cardiovascular**

- Heart Disease
- Chest Pain
- Swelling of Ankles
- High Blood Pressure
- Palpitations/Fluttering
- Stroke
- Heart Murmurs
- Rheumatic Fever
- Varicose Veins

21. **Musculoskeletal**

- Neck/Shoulder Pain
- Muscle Spasms/Cramp
- Arm Pain
- Upper Back Pain
- Mid Back Pain
- Low Back Pain
- Leg Pain
- Joint Pain (if so, where?): \_\_\_\_\_

22. **Endocrine**

- Hypothyroid
- Hypoglycemia
- Hyperthyroid
- Diabetes Mellitus
- Night Sweats
- Feeling Hot or Cold

23. **Gastrointestinal**

- Ulcers
- Changes in Appetite
- Nausea/Vomiting
- Epigastric Pain
- Passing Gas
- Heartburn
- Belching
- Gall Bladder Disease
- Liver Disease
- Hepatitis B or C
- Hemorrhoids
- Abdominal Pain

24. **Genito-Urinary Tract**

- Kidney Disease
- Painful Urination
- Frequent UTI
- Frequent Urination
- Kidney Stones
- Impaired Urination
- Blood in Urine
- Frequent Urination at Night

25. **Emotional**

- Mood Swings
- Nervousness
- Mental Tension

26. **Female Reproductive/Breasts**

- Irregular Cycles
- Breast Lumps/Tenderness
- Nipple Discharge
- Heavy Flow
- Vaginal Discharge
- Premenstrual Problems
- Clotting
- Bleeding Between Cycles
- Menopausal Symptoms
- Difficulty Conceiving
- Painful Periods

27. **Male Reproductive**

- Sexual Difficulties
- Prostrate Problems
- Testicular Pain/Swelling
- Penile Discharge

28. **Other**

- Anemia
- Cancer
- Rashes
- Eczema/Hives
- Cold Hands/Feet

29. **Menstrual/Birthing History:** a. Age of First Menses: \_\_\_\_\_ b. # of Days of Menses: \_\_\_\_\_ c. Length of Cycle: \_\_\_\_\_  
 d. Birth Control Type: \_\_\_\_\_ e. # of Pregnancies: \_\_\_\_\_ f. # of Miscarriages: \_\_\_\_\_ g. # of Abortions: \_\_\_\_\_  
 h. # of Live Births: \_\_\_\_\_

Is there anything else we should know? \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

How did you hear about us? \_\_\_\_\_