The Health & Longevity Clinic

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Name_____

Address_____ Town_____ State_____ Zip_____

Primary Phone_____ Cell or other_____

E-mail_____

In Emergency Notify_____ Phone_____

Date of Birth_____ Place_____ Time (if known)_____

Chinese Astrology: Year_____ Month_____ Hour_____

Profession_____ How Long?_____

Height_____ Weight_____ Current Age_____

Single / Married / Divorced - Children_____ Ages_____

Have you been treated with acupuncture before?_____ Who?_____

For What?_____ Results_____

How did you hear about us?_____

What has brought you here?_____

_____

How long has this been going on, and how did it begin?_____

_____

Diagnosis?_____

What kinds of treatment have you tried?_____

Does anything make it better?_____

Worse?_____

Current Medications & Supplements_____

_____

_____

Other Concerns_____

I recognize that the major factor in my health is myself, that no one can do my healing for me, and that my participation in my own care is key. That without following the recommendations, taking the herbs, doing the practices, shifting the lifestyle, etc., little can be expected and no promise of result is offered.

_____

Signature Date

Family Medical History (General Health):

Mother's Side:_____

Father's Side:_____

Siblings:_____

If above deceased, cause of death:_____

Childhood Health: (Physical)_____(Emotional)_____

Location of upbringing:_____

Current Emotional Health:_____

Current predominant emotion:_____

Current Quality of Life:_____

Current Relationship/Quality:_____

Is there much stress in your life?_____What?_____

Hobbies and recreational Habits:_____

Favorite time of year:_____Worst time of year:_____

Do you have a regular exercise program?_____Please describe:_____

_____

Travel abroad within the past year? Where?_____

Do you feel you have a good appetite?_____Good eating habits?_____

Please describe your average daily diet:

Morning Afternoon Evening

_____

_____

_____

Proportion of raw food_____to cooked food_____

Do you get any cravings?_____What/When?_____

Prefered Tastes: Sour_____ Bitter_____ Sweet_____ Spicy_____ Salty_____

How many packs of cigarettes do you smoke a day?_____

How much coffee, tea or cola do you drink per week?_____

How much alcohol do you drink per week?_____

Please describe any recreational drug use: (This information is strictly confidential)_____

_____

Have you ever abstained from or "quit" anything?_____

Do you have any nervous habits?_____

What factors in your life seem most important to your daily health?_____

_____

What factors in your life seem most destructive to your daily health?_____

_____

Please check if you now have, or if you have ever had, any of the following:

____Cancer	____Arthritis	____Hepatitis	____High Blood Pressure
____Diabetes	____Asthma	____HIV/AIDS	____Thyroid Disorders
____Stroke	____Allergies	____Herpes	____Rheumatic Fever
____Heart Disease	____Seizures	____Tuberculosis	____Addictive Disorders
____Heart Attack	____Parasites	____Weight Disorders	____Mental Illness

Please explain:_____

Please check if you have experienced within the past three months:
Mark one check if occassionally, two checks if frequent, and three checks if it is a constant problem.

General:
___Fevers
___Chills
___Fatigue
___Poor Sleep/Insomnia
___Dream Disturbed Sleep
___Depression
___Mania
___Emotional Changes
___Tremors
___Seizures
___Night Sweats
___Day Sweating
___Poor Balance
___Weight Loss
___Weight Gain
___Poor Appetite
___Change in Appetite
___Peculiar tastes or smells
___Sudden energy drops
What time of day?_____
___Strong thirst, for hot or cold drinks?_____
___Headaches
___Localized Weakness
___Bleeding or Bruising
___Joint Pain

Cardiovascular:
___High Blood pressure
___Low Blood Pressure
___Irregular Heartbeat
___Chest Pain / Angina
___Dizziness
___Fainting
___Cold Sweats
___Swelling of Feet
___Swelling of Hands
___Difficulty in Breathing
___Cold Hands or Feet
___Phlebitis
___Blood Clots
___Palpitations

Respiratory:
___Cough
___Asthma
___Bronchitis
___Pain with Deep Breaths
___Difficulty in Breathing When Laying Down
___Easily Winded with Exertion
___Shortness of Breath
___Coughing of Blood
___Production of Phlegm
What Color?_____

Gastrointestinal:
___Nausea
___Vomiting
___Indigestion
___Ulcers
___Abdominal Pain or Cramps
___Digestive Disorders
___Belching
___Bad Breath
___Gas
___Constipation
___Diarrhea
___Blood in Stools
___Hemorroids
___Hernia

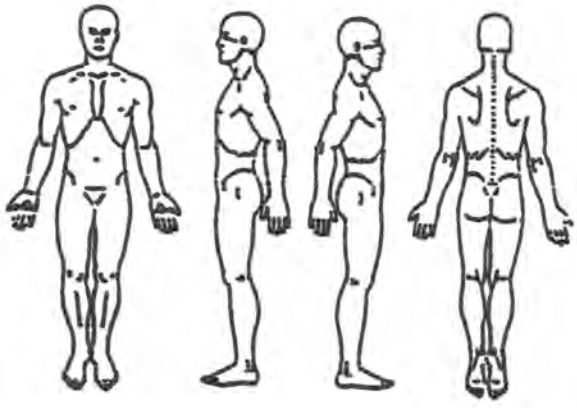
Genito-urinary:
___Pain on Urination
___Urgent Urination
___Frequent Urination
___Unable to Hold Urine
___Decrease in Urine
___Blood in Urine
___Impotency/Infertility
___Genital Sores
___Kidney Stones
___Waking Up to Urinate
How Often?_____

Musculoskeletal:
___General aches
___Muscular Atrophy
___ Muscular Weakness
___Arthritis
___Joint Instability
___Muscle Cramps
___Spasms
___Recent Sprains
___Injuries or Falls

Please Circle on the diagram any areas of any type of pain or injury.

Please try and describe the type and quality of the pain.

_____



Ear, Nose & Throat:

___Ringing in Ears
_____Poor Hearing
____ Earaches
_____Ear Discharge
___Sinus Problems
___Nose Bleeds
____Recurrent Sore Throat
____Sores on Lips or Tounge
____Thirst w/o desire to drink
____Teeth Problems
____Grinding Teeth
____Gum Problems
____Facial Pain
____Jaw Clicks

Eyes & Vision:

_____Glasses
____ Poor Vision
_____Blurred Vision
____Eye Strain
____Cataracts
____Glaucoma
____Eye Pain
____Eye Dryness
____Eye Redness
____Color Blindness
____Night Blindness
____Floaters in Vision
____Spots in Front of Eyes
____Eye Itchiness

Skin and Hair:

____Rashes
____Itching
____Eczema
____Ulcerations
____Hives
____Pimples
____Recent Moles
____Dandruff
____Loss of Hair
____Any Change in Hair or Skin Texture

Neuropsychological:

____Siezures
____Concussion
____Dizziness
____Headaches
____Migraines
____Areas of Numbness
____Lack of Coordination
____Loss of Balance
____Fainting
____Disorientation
____Irritability
____Easily Susceptible to Stress
____Easily Angered
____Depression
____Mania
____Anxiety
____Poor Memory

Have you ever been treated for emotional, neurological or psychological problems?
Please explain_____

Pregnancy and Gynecology:

_____Age at first Menses
_____Days between Menses
_____Duration of Menses
_____First Date of Last Menses
_____Heavy or _____Light
_____Irregular Periods
_____Painful Periods
_____Number of Pregnancies
_____Number of Births
_____Miscarriages
_____Abortions
_____Difficult Births
_____Premature Births
_____Breast Lumps
_____Clots
Birth Control?_____
What Type?_____
How Long?_____
Currently?_____
_____Fertility Problems
_____Vaginal Discharge
_____Vaginal Sores
_____Last PAP Smear

Do you experience changes in Body &/or Psyche prior to menstruation?_____

Are there any other problems, conditions or observations that you would like to discuss?_____

_____

_____

What are your goals for your health & life?_____

_____

_____