Equilibrium Health + Wellness

Today's Date:_____/_____/_____

Confidential Patient Health Record

Patient Information

Name: _____Birth Date: _____

Social Security Number: _____

Address: _____ City: _____

State: _____ Zip: _____

Primary Phone: _____

Secondary Phone: _____ Email: _____

Gender: _____ Relationship Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Other

Primary Care Physician: _____ Phone: _____

Emergency Contact: _____ Phone: _____

Have you had acupuncture before? ☐ Yes ☐ No If yes, when? _____ for what? _____ by whom? _____

Main Complaint

Main Complaint: _____

How long have you had this problem? _____

What has/seems to cause this problem? _____

My symptoms are: ☐ Severe ☐ Moderate ☐ Mild My symptoms are: ☐ Improving ☐ Worsening ☐ Unchanged

What makes your symptoms improve? _____

What makes your symptoms worse? _____

Do your symptoms affect your daily activities? ☐ Yes ☐ No If so, please describe: _____

Have you received a medical diagnosis? ☐ Yes ☐ No If so, please list: _____

What are you hoping to achieve with treatment?

_____

Medical History

Please check any of the following which have ever affected you and indicate date.

☐ Addiction	☐ Candida	☐ Gallstones	☐ Hypotension	☐ Rheumatism
☐ AIDS	☐ Chronic fatigue	☐ Glaucoma	☐ Kidney stones	☐ Seizures
☐ Alcoholism	☐ Colitis/bowel disease	☐ Goiter	☐ Malaria	☐ Stroke
☐ Anemia	☐ Diabetes	☐ Gout	☐ Meningitis	☐ STD
☐ Arteriosclerosis	☐ Digestive disorders	☐ Heart Disease	☐ Mononucleosis	☐ Thyroid problems
☐ Arthritis	☐ Eating disorders	☐ Hernia	☐ Multiple sclerosis	☐ Tonsillitis
☐ Asthma	☐ Emotional imbalance	☐ Hepatitis	☐ Nephritis	☐ Tuberculosis
☐ Breast lumps	☐ Emphysema	☐ Herpes	☐ Neuralgia	☐ Ulcers
☐ Bursitis	☐ Epilepsy	☐ High cholesterol	☐ Paralysis	☐ Urinary problems
☐ Cancer	☐ Fibromyalgia	☐ Hypertension	☐ Prostate problems	☐ Whooping cough

☐ Other: _____

Medications taken in last 3 months, including over-the-counter medications

MEDICATION	DOSAGE	REASON	HOW LONG
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Please list any vitamins, supplements, or herbal medicines that you are taking: _____

_____

_____

Please list any allergies or adverse reactions, especially related to food and/or drugs:_____

_____

Do you currently have any of the following? ☐ Cold/Flu ☐ Infection/Inflammation ☐ Menstruation ☐ Pregnancy/Lactations

Family Medical History

Do you have a family history of any of the following diseases or conditions? Check all that apply:

☐ Allergies	☐ Asthma	☐ Hypertension	☐ Seizures
☐ Anemia	☐ Cancer	☐ Kidney Disease	☐ Stroke
☐ Arteriosclerosis	☐ Diabetes	☐ Mental Health	☐ Other_____
☐ Arthritis	☐ Heart Disease	☐ Obesity	_____

Personal/Social History

Please indicate the use and frequency of the following:

Cigarettes ☐ Yes ☐ No how many per day? _____ since when? _____ Alcohol ☐ Yes ☐ No amount _____

Recreational drugs ☐ Yes ☐ No type _____ amount _____ since when? _____

Coffee ☐ Yes ☐ No amount _____ Soda ☐ Yes ☐ No amount_____ Water ☐ Yes ☐ No amount_____

Please describe average daily diet:

Morning: _____

Afternoon: _____

Evening: _____

Please check the box that describes the taste you favor/most often crave? ☐ Salty ☐ Sweet ☐ Bitter ☐ Spicy ☐ Sour

How do you feel about the following areas of your life?

	GREAT	GOOD	FAIR	POOR	BAD	COMMENTS
Significant Other	☐	☐	☐	☐	☐	_____
Family	☐	☐	☐	☐	☐	_____
Diet	☐	☐	☐	☐	☐	_____
Sex	☐	☐	☐	☐	☐	_____
Self	☐	☐	☐	☐	☐	_____
Work	☐	☐	☐	☐	☐	_____
Spirituality	☐	☐	☐	☐	☐	_____

Please check any of the following that apply to you now or in the past three months

General

PAST	CURRENT	CONDITION	PAST	CURRENT	CONDITION	PAST	CURRENT	CONDITION
☐	☐	Shortness of breath	☐	☐	Poor appetite	☐	☐	Allergies
☐	☐	Poor coordination	☐	☐	Excess appetite	☐	☐	Fever
☐	☐	Vertigo/Dizziness	☐	☐	Strong thirst	☐	☐	Chills
☐	☐	Bleed or bruise easily	☐	☐	Fatigue	☐	☐	Heavy body
☐	☐	Hot or cold intolerance	☐	☐	Poor sleeping	☐	☐	Weight loss
☐	☐	Nervousness/Irritability	☐	☐	Night sweats	☐	☐	Weight gain
☐	☐	Sudden energy drop	☐	☐	Sweat easily	☐	☐	Tremors
☐	☐	Localized weakness	☐	☐	Swollen glands	☐	☐	Mood changes
☐	☐	Frequent infection	☐	☐	Cold hands/feet	☐	☐	Cravings

Psychological

PAST	CURRENT	CONDITION	PAST	CURRENT	CONDITION	PAST	CURRENT	CONDITION
☐	☐	Loss of control	☐	☐	Irritability	☐	☐	Depression
☐	☐	Anxiety	☐	☐	Bad temper	☐	☐	Panic attacks
☐	☐	Suicidal thoughts	☐	☐	Suicidal attempts	☐	☐	Easily stressed
☐	☐	Seeing a therapist	☐	☐	Other: _____			

Skin and Hair

PAST	CURRENT	CONDITION	PAST	CURRENT	CONDITION	PAST	CURRENT	CONDITION
☐	☐	Rashes	☐	☐	Dry skin	☐	☐	Itching
☐	☐	Eczema	☐	☐	Pimples	☐	☐	Tumors/Lumps
☐	☐	Hives	☐	☐	Recent moles	☐	☐	Loss of hair
☐	☐	Tumors/Lumps	☐	☐	Ulceration	☐	☐	Psoriasis
☐	☐	Slow wound healing	☐	☐	Other: _____			

Head, Eyes, Ears, Nose, and Throat

PAST	CURRENT	CONDITION	PAST	CURRENT	CONDITION	PAST	CURRENT	CONDITION
☐	☐	Dizziness	☐	☐	Color blindness	☐	☐	Ringing in ears
☐	☐	Headache	☐	☐	Vision changes	☐	☐	Poor hearing
☐	☐	Migraine	☐	☐	Cataracts	☐	☐	Ear pain
☐	☐	Concussion	☐	☐	Glaucoma	☐	☐	Sinus problems
☐	☐	Facial pain	☐	☐	Spots in the eyes	☐	☐	Runny nose
☐	☐	Sore throat	☐	☐	Night blindness	☐	☐	Sneezing
☐	☐	Sores on lips or tongue	☐	☐	Blurry vision	☐	☐	Congestion
☐	☐	Grinding teeth	☐	☐	Eye pain	☐	☐	Loss of smell
☐	☐	Jaw clicks	☐	☐	Dry eyes	☐	☐	Nosebleeds
☐	☐	Gum problems	☐	☐	Red eyes	☐	☐	Peculiar smells
☐	☐	Teeth problems	☐	☐	Itchy eyes	☐	☐	Peculiar tastes
☐	☐	Excessive saliva	☐	☐	Other: _____			

Cardiovascular

PAST	CURRENT	CONDITION	PAST	CURRENT	CONDITION	PAST	CURRENT	CONDITION
☐	☐	High blood pressure	☐	☐	Swelling of hands	☐	☐	Fainting
☐	☐	Low blood pressure	☐	☐	Swelling of ankles	☐	☐	Blood clots
☐	☐	Irregular heartbeat	☐	☐	Cold hands/feet	☐	☐	Palpitations
☐	☐	High cholesterol	☐	☐	Heart murmur	☐	☐	Heart murmur
☐	☐	Poor circulation	☐	☐	Heart valve issues	☐	☐	Chest pain
☐	☐	Varicose veins	☐	☐	Other: _____			

Respiratory

PAST	CURRENT	CONDITION	PAST	CURRENT	CONDITION	PAST	CURRENT	CONDITION
☐	☐	Shortness of breath	☐	☐	Cough	☐	☐	Sleep apnea
☐	☐	Pain with deep breath	☐	☐	Bronchitis	☐	☐	Asthma
☐	☐	Tightness of chest	☐	☐	Emphysema	☐	☐	Wheezing
☐	☐	Difficulty breathing	☐	☐	Frequent colds/flu	☐	☐	Pneumonia
☐	☐	Excessive phlegm	☐	☐	Other: _____			

Gastrointestinal

PAST	CURRENT	CONDITION	PAST	CURRENT	CONDITION	PAST	CURRENT	CONDITION
☐	☐	Burning of anus	☐	☐	Constipation	☐	☐	Hemorrhoids
☐	☐	Chronic laxative use	☐	☐	Diarrhea	☐	☐	Gas/bloating
☐	☐	Pain with defecation	☐	☐	Blood in stool	☐	☐	Indigestion
☐	☐	Incomplete defecation	☐	☐	Food in stools	☐	☐	Belching
☐	☐	Light colored stools	☐	☐	Black stools	☐	☐	Nausea/vomit
☐	☐	Foul smelling stools	☐	☐	Rectal pain	☐	☐	Hiccups
☐	☐	Abdominal pain	☐	☐	Bad breath	☐	☐	Acid reflux
☐	☐	Hiatal hernia	☐	☐	Other: _____			

Genito-Urinary

PAST	CURRENT	CONDITION	PAST	CURRENT	CONDITION	PAST	CURRENT	CONDITION
☐	☐	Pain on urination	☐	☐	Kidney stones	☐	☐	Herpes
☐	☐	Urgency to urinate	☐	☐	Increased libido	☐	☐	Bedwetting
☐	☐	Unable to hold urine	☐	☐	Decreased libido	☐	☐	STDs
☐	☐	Decreased in urine flow	☐	☐	Frequent UTIs	☐	☐	Genital itching
☐	☐	Incomplete urination	☐	☐	Sores on genitals	☐	☐	Blood in urine
☐	☐	Nighttime urination	☐	☐	Other: _____			

Male Reproductive (Men Only)

PAST	CURRENT	CONDITION	PAST	CURRENT	CONDITION	PAST	CURRENT	CONDITION
☐	☐	Prostate problems	☐	☐	Penile discharge	☐	☐	Impotence
☐	☐	Sexual dysfunction	☐	☐	Testicular lumps	☐	☐	Testicular pain

Have you had a prostate exam? ☐ Yes ☐ No If yes, when? _____ results? _____

Gynecological (Women only. If you have already had menopause, please describe your past menstruation)

Is there a possibility that you are pregnant? ☐ Yes ☐ No Date of last pap smear: _____

PAST	CURRENT	CONDITION	PAST	CURRENT	CONDITION	PAST	CURRENT	CONDITION
☐	☐	Painful periods	☐	☐	Irregular periods	☐	☐	Mastitis
☐	☐	Vaginal discharge	☐	☐	Uterine bleeding	☐	☐	Fibroids
☐	☐	Infertility	☐	☐	Breast lumps	☐	☐	Endometriosis
☐	☐	Yeast infection	☐	☐	Vaginitis	☐	☐	PID
☐	☐	Other: _____						

Age of first period: _____ Number of days between periods: _____ Number of days of flow: _____

Menstruation: Start date of last cycle: _____

Pregnancy: # pregnancies: _____ # births: _____ # miscarriages _____ # abortions _____ # premature births _____

Menopause: Age of menopause: _____ Menopausal symptoms: _____

Musculoskeletal/Neurological

PAST	CURRENT	CONDITION	PAST	CURRENT	CONDITION	PAST	CURRENT	CONDITION
☐	☐	Neck tightness/pain	☐	☐	Knee pain	☐	☐	Hernia
☐	☐	Shoulder pain	☐	☐	Muscle weakness	☐	☐	Seizures
☐	☐	Hand/wrist pain	☐	☐	Muscle pain	☐	☐	Tremors
☐	☐	Back pain	☐	☐	Joint sprain	☐	☐	Numbness
☐	☐	Hip pain	☐	☐	Joint disorders	☐	☐	Tingling
☐	☐	Sciatica	☐	☐	Scoliosis	☐	☐	Paralysis
☐	☐	Other: _____						

Please feel free to list/describe any other issues you would like to discuss

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

The information on this form is correct and accurate to the best of my knowledge.

Signature: _____ Date: _____