

Patient Information

Patient Name: _____

Date of Birth: _____ Age: _____ Gender/Sex: _____

Single: _____ Married: _____ Separated: _____ Divorced: _____ Widowed: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____

Email: _____

Occupation: _____ Employer: _____

Emergency Contact:

Name & Relation: _____ Phone #: _____

How did you hear about us?: _____

Would like to learn additional health tips and join our newsletter? Of course I would! Not interested
(Promise there is some good stuff in it!)

I understand that I am financially responsible for all charges whether or not paid by my insurance. I am aware that some and perhaps all of the services provided may be non-covered services under my insurance. I am also aware that verification of insurance benefits is not a guarantee of payment or coverage. I understand that any outstanding account balances will be sent to collections after 90 days if payment has not been remitted.

An Eastern Medicine Practitioner in the State of South Carolina is not licensed to prescribe pharmaceutical drugs. If you want the clinic to treat a condition has been diagnosed by your doctor and is not an emergency situation we will be happy to do so, so long as the condition has been diagnosed by your doctor and is not an emergency situation. If I decide want to alter my pharmaceutical regime in any way the I must consult my doctor before doing so. I have read the above and I understand and accept these policies.

Date: _____

Patient Signature: _____

Health History Questionnaire

Major Complaint(s):

- _____
- _____
- _____
- _____

How do these conditions affect your daily activities? _____

Why do you want this to be better? _____

Primary Physician: _____

Other physicians/therapists: _____

***We find that when your **healthcare providers** are up to date with your treatment progress, it makes it easier for all of us to better help you improve your health. Is it okay if we contact the above healthcare providers to update them on the treatments you are receiving here? YES PLEASE NO THANKS

Medication(s) you are currently taking:

Drug Name	Taking For	Taking Since

Supplements (vitamins, herbs, minerals, etc.): _____

Health History Questionnaire

List all hospital stays, surgeries, or major illnesses that you have had since birth

Year Occurred

Test	Year	Test Results
<input type="checkbox"/> Physical	_____	_____
<input type="checkbox"/> Cholesterol	_____	_____
<input type="checkbox"/> Prostate	_____	_____
<input type="checkbox"/> Mammogram	_____	_____
<input type="checkbox"/> Pap Smear	_____	_____
<input type="checkbox"/> Blood	_____	_____
<input type="checkbox"/> HIV/STD	_____	_____

Please check if you have or had any of the following conditions

- | | | | |
|----------------------------------------|---------------------------------------|----------------------------------------------|-----------------------------------------|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Syphilis | <input type="checkbox"/> Mumps | <input type="checkbox"/> Jaundice |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> CVA (Stroke) | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Vein Condition |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Gonorrhea | <input type="checkbox"/> Bleeding Tendency | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Meningitis | <input type="checkbox"/> Measles | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Chicken Pox |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> HIV | <input type="checkbox"/> Nervous Disorder | <input type="checkbox"/> Polio |
| <input type="checkbox"/> Paralysis | <input type="checkbox"/> High Fever | <input type="checkbox"/> Mononucleosis | <input type="checkbox"/> Migraines |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Cancer | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Anxiety |

Health History Questionnaire

Please check all the symptoms that you are currently experiencing or experienced in the last 6 months.

PAIN CONDITION QUESTIONS

What makes the pain better?

- Soft pressure
- Hard pressure
- Cold
- Heat
- Exercise
- Rest
- Other: _____

What makes the pain worse?

- Soft pressure
- Hard pressure
- Cold
- Heat
- Exercise
- Rest
- Other: _____

TOTAL BOXES CHECKED: _____

DESCRIBE YOUR PAIN

- Sharp
- Fixed
- Burning
- Moving

- Cramping
- Aching
- Dull
- Other: _____

TOTAL BOXES CHECKED: _____

LUNG & KIDNEY FUNCTION

- Shortness of breath
- General weakness
- Daily chronic fatigue & malaise
- Low energy

- Difficulty keeping eyes open (daytime)
- Easily catch colds
- Feel worse after exercise

TOTAL BOXES CHECKED: _____

HEART FUNCTION

- Anxiety
- Sores on tip of tongue
- Restlessness
- Mental confusion
- Poor Memory/forgetfulness

- Chest pain traveling to shoulder
- Frequent dreams
- Wake unrefreshed
- Trouble falling and/or staying asleep
- Palpitations, fluttering, skipped beats

TOTAL BOXES CHECKED: _____

SLEEP QUALITY

Total hours of sleep per night _____

What time do you go to bed? _____

Restless sleep? _____

How many times do you wake up? _____

Feel hot during the night? _____

Do you feel refreshed when you wake up? _____

Health History Questionnaire

SPLEEN FUNCTION

- | | |
|--------------------------------------------------|------------------------------------------------------------|
| <input type="checkbox"/> Low appetite | <input type="checkbox"/> Cold hands, fingers, nose |
| <input type="checkbox"/> Abrupt weight gain | <input type="checkbox"/> Fatigue |
| <input type="checkbox"/> Dizziness upon standing | <input type="checkbox"/> Bruise easily |
| <input type="checkbox"/> Abdominal bloating | <input type="checkbox"/> Prolapsed organs: _____ |
| <input type="checkbox"/> Abdominal gas | <input type="checkbox"/> Limbs feel weak or lacks strength |
| <input type="checkbox"/> Worry, Overthinking | <input type="checkbox"/> Craves sugar |

TOTAL BOXES CHECKED: _____

SMALL/LARGE INTESTINE FUNCTION

- | | |
|-------------------------------------------------|----------------------------------------------------------------------|
| <input type="checkbox"/> Loose stools, unformed | <input type="checkbox"/> Blood in stools |
| <input type="checkbox"/> Constipated | <input type="checkbox"/> Mucous in stools |
| <input type="checkbox"/> Incomplete stools | <input type="checkbox"/> Undigested food in stools |
| <input type="checkbox"/> Foul smelling/odor | <input type="checkbox"/> Excessive wiping (more than 4 times), messy |
| <input type="checkbox"/> Explosive evacuation | <input type="checkbox"/> Push to initiate, not easy to go |
| <input type="checkbox"/> Diarrhea | |

TOTAL BOXES CHECKED: _____

LUNG FUNCTION

- | | |
|---------------------------------------------------------|------------------------------------------------------------------|
| <input type="checkbox"/> Nasal discharge (color: _____) | <input type="checkbox"/> Sneezing |
| <input type="checkbox"/> Cough | <input type="checkbox"/> Itchy eyes |
| <input type="checkbox"/> Nose bleeds | <input type="checkbox"/> Overall achy feeling in body |
| <input type="checkbox"/> Sinus congestion | |
| <input type="checkbox"/> Allergies (type: _____) | <input type="checkbox"/> Sore throat |
| <input type="checkbox"/> Alternation of chills/fever | <input type="checkbox"/> Difficulty breathing |
| <input type="checkbox"/> Dry mouth | <input type="checkbox"/> Smoke cigarettes (packs per day: _____) |
| <input type="checkbox"/> Dry throat | <input type="checkbox"/> Sadness |
| <input type="checkbox"/> Dry nose | <input type="checkbox"/> Melancholy |
| <input type="checkbox"/> Dry skin | |

TOTAL BOXES CHECKED: _____

STOMACH FUNCTION

- | | |
|------------------------------------------------------------------------------|---------------------------------------------|
| <input type="checkbox"/> Burning sensation after eating | <input type="checkbox"/> Acid regurgitation |
| <input type="checkbox"/> Large appetite, finish your plate, excessive hungry | <input type="checkbox"/> Ulcer |
| <input type="checkbox"/> Bad Breath | <input type="checkbox"/> Belching |
| <input type="checkbox"/> Canker sores (mouth), sores on lips | <input type="checkbox"/> Hiccups |
| <input type="checkbox"/> Bleeding, swollen or painful gums | <input type="checkbox"/> Stomach pain |
| <input type="checkbox"/> Heartburn | <input type="checkbox"/> Vomiting |

TOTAL BOXES CHECKED: _____

Health History Questionnaire

DAMPNESS TRAPPED IN THE BODY

- | | |
|--------------------------------------------------------|-------------------------------------------|
| <input type="checkbox"/> Bodily sensation of heaviness | <input type="checkbox"/> Swollen feet |
| <input type="checkbox"/> Mental heaviness | <input type="checkbox"/> Swollen joints |
| <input type="checkbox"/> Mental sluggishness | <input type="checkbox"/> Chest congestion |
| <input type="checkbox"/> Mental fogginess | <input type="checkbox"/> Nausea |
| <input type="checkbox"/> Swollen hands | <input type="checkbox"/> Snoring |

TOTAL BOXES CHECKED: _____

LIVER FUNCTION (EYES)

- | | |
|------------------------------------|-------------------------------------------------|
| <input type="checkbox"/> Itchy | <input type="checkbox"/> Gritty |
| <input type="checkbox"/> Bloodshot | <input type="checkbox"/> Blurry vision |
| <input type="checkbox"/> Hot | <input type="checkbox"/> Decreased night vision |
| <input type="checkbox"/> Dry | |
| <input type="checkbox"/> Watery | |

TOTAL BOXES CHECKED: _____

LIVER, GALL BLADDER FUNCTION

- | | |
|-----------------------------------------------------------------------|-----------------------------------------------------------------------|
| <input type="checkbox"/> Alternating diarrhea & constipation | <input type="checkbox"/> Muscle spasms |
| <input type="checkbox"/> Pain under ribs | <input type="checkbox"/> Seizures, Convulsions |
| <input type="checkbox"/> Tight sensation in chest | <input type="checkbox"/> Bitter taste upon waking |
| <input type="checkbox"/> You frequently find yourself sighing | <input type="checkbox"/> Lump in the throat |
| <input type="checkbox"/> Anger easily | <input type="checkbox"/> Neck tension |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Shoulder tension |
| <input type="checkbox"/> Frustration, irritability, grumpy, impatient | <input type="checkbox"/> Limited range of motion in neck |
| <input type="checkbox"/> You have "11" lines between eyebrows | <input type="checkbox"/> Limited range of motion in shoulder |
| <input type="checkbox"/> Skin rashes | <input type="checkbox"/> Alcohol consumption (per day: _____) |
| <input type="checkbox"/> Headache at the top of the head | <input type="checkbox"/> Recreational drug use (which: _____) |
| <input type="checkbox"/> Headache at temples | <input type="checkbox"/> Nails pale, brittle, ridges/lines |
| <input type="checkbox"/> Premenstrual Symptoms | <input type="checkbox"/> Pale lips |
| <input type="checkbox"/> Tingling sensation | <input type="checkbox"/> High-pitched ringing in ears |
| <input type="checkbox"/> Numbness | <input type="checkbox"/> Gallstones |
| <input type="checkbox"/> Muscle twitching | <input type="checkbox"/> STD's (which: _____) |
| <input type="checkbox"/> Muscle cramping at night | <input type="checkbox"/> Blush easily with emotions like anger/stress |

TOTAL BOXES CHECKED: _____

Health History Questionnaire

KIDNEY FUNCTION (OVERALL TEMPERATURE)

- | | |
|----------------------------------------------------|--------------------------------------------------------------------|
| <input type="checkbox"/> Cold hands | <input type="checkbox"/> Afternoon flushes |
| <input type="checkbox"/> Cold fingers | <input type="checkbox"/> Heat in the hands, feet & chest |
| <input type="checkbox"/> Cold feet | <input type="checkbox"/> Hearing loss or declining |
| <input type="checkbox"/> Cold toes only | <input type="checkbox"/> Tinnitus low pitch ringing |
| <input type="checkbox"/> Cold knees | <input type="checkbox"/> Hot flashes any time of the day |
| <input type="checkbox"/> Sweaty hands | <input type="checkbox"/> Thirsty (drink lots or sip small amounts) |
| <input type="checkbox"/> Sweaty feet | <input type="checkbox"/> Perspire easily |
| <input type="checkbox"/> Hot body temp. sensation | <input type="checkbox"/> Lack of perspiration |
| <input type="checkbox"/> Cold body temp. sensation | |

TOTAL BOXES CHECKED: _____

KIDNEY & URINARY BLADDER FUNCTION

- | | |
|------------------------------------------------------------|------------------------------------------------------------------------|
| <input type="checkbox"/> Frequent cavities, teeth problems | <input type="checkbox"/> Low-pitched ringing in ears |
| <input type="checkbox"/> Easily broken bones | <input type="checkbox"/> Kidney stones |
| | <input type="checkbox"/> Crave large amounts of liquid |
| <input type="checkbox"/> Weak or sore knees | <input type="checkbox"/> Crave small amounts of liquid (little thirst) |
| <input type="checkbox"/> Cold sensation in knees | <input type="checkbox"/> Lack of bladder control |
| | <input type="checkbox"/> Wake during the night to urinate |
| <input type="checkbox"/> Low back pain | <input type="checkbox"/> Fear, Easily Startled |
| <input type="checkbox"/> Dry mouth/throat | <input type="checkbox"/> Hearing loss |
| <input type="checkbox"/> Excessive hair loss | |

TOTAL BOXES CHECKED: _____

URINATION (BLADDER FUNCTION)

- | | |
|--------------------------------------------------------------------|---------------------------------------------|
| <input type="checkbox"/> Color: Yellow, reddish | <input type="checkbox"/> Burning sensation |
| <input type="checkbox"/> History UTI's, last time was _____ | <input type="checkbox"/> Painful |
| <input type="checkbox"/> Cloudy | <input type="checkbox"/> Dribbling, leaking |
| <input type="checkbox"/> Scanty | <input type="checkbox"/> Difficult |
| <input type="checkbox"/> Profuse | <input type="checkbox"/> Urgent |
| <input type="checkbox"/> Strong odor | |
| <input type="checkbox"/> Night time urination, ___ times per night | |
| <input type="checkbox"/> Frequent like >10 times per day | |

TOTAL BOXES CHECKED: _____

Libido

- Low
 High

Health History Questionnaire

WOMEN ONLY

- Do you have a regular menstrual cycle?: Yes No
Are you pregnant?: Yes No
Do you have bleeding between periods? Yes No
Do you have excessive vaginal discharge? Yes No

MENSTRUAL CYCLE SYMPTOMS

- | | |
|--------------------------------------------|---------------------------------------|
| <input type="checkbox"/> Nausea | <input type="checkbox"/> Migraines |
| <input type="checkbox"/> Vomiting | <input type="checkbox"/> Dull pain |
| <input type="checkbox"/> Food cravings | <input type="checkbox"/> Sharp pain |
| <input type="checkbox"/> Water retention | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Breast swelling | <input type="checkbox"/> Irritability |
| <input type="checkbox"/> Breast tenderness | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Other: _____ |

TOTAL BOXES CHECKED: _____

Number of children _____ Number of pregnancies _____ Age of first menses _____
Date of start of last menses _____ How many total cycle days per month? _____
Bleed for _____ days Pain during bleeding _____ Describe your flow _____

MEN ONLY

- | | |
|------------------------------------------|------------------------------------------------------------------|
| <input type="checkbox"/> Swollen testes | <input type="checkbox"/> Premature ejaculation |
| <input type="checkbox"/> Testicular pain | <input type="checkbox"/> Coldness or numbness external genitalia |
| <input type="checkbox"/> Impotence | <input type="checkbox"/> Other: _____ |
- TOTAL BOXES CHECKED: _____

Nutrition

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

Type of Diet: _____

Current weight: _____ Height: _____