

Patient Health History

Welcome to Mill-e-Moto, it is our goal to help each patient improve their quality of life and to achieve optimum health. In order to serve you best we encourage you to fill out this survey in as much detail as possible. All symptoms that you experience are relevant and important to us as TEAM practitioners. All information will be held in strict confidence.

Name: _____ Date: ____/____/____
(first) (middle) (last)

Address: _____ City/State: _____ Zip: _____

Telephone#: (H) _____ (C) _____ E-Mail: _____

Emergency Contact (Name /Telephone #): _____

Date of Birth: ____/____/____ Age: _____ Gender: _____ Marital status: _____

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 Encompass Acupuncture Health in order of importance:

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 and their dosage:

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: _____

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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	_____	_____	_____	_____	_____	_____
Stroke	_____	_____	_____	_____	_____	_____
Mental Illness	_____	_____	_____	_____	_____	_____
Asthma/Hay fever/Hives	_____	_____	_____	_____	_____	_____
Kidney Disease	_____	_____	_____	_____	_____	_____
Age (at death)	_____	_____	_____	_____	_____	_____
Cause of Death	_____	_____	_____	_____	_____	_____

Please CHECK any that you have now, and UNDERLINE any that you have experienced in the past

15. Emotional

- ☐ Mood Swings
- ☐ Nervousness
- ☐ Mental Tension

16. Energy and Immunity

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

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. Respiratory

- ☐ Pneumonia
- ☐ Frequent Common Cold
- ☐ Difficulty Breathing
- ☐ Emphysema

☐ Persistent Cough

☐ Pleurisy

☐ Asthma

☐ Tuberculosis

☐ Shortness of Breath

☐ Other Respiratory Problems

19. Cardiovascular

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

20. 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

Patient Initials: _____ Patient DOB: ____/____/____

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21. Genito-Urinary Tract

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

22. 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

23. Male Reproductive

- ☐ Sexual Difficulties
- ☐ Prostate Problems
- ☐ Testicular Pain/Swelling
- ☐ Penile Discharge

24. 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?): _____

25. Neurological

- ☐ Vertigo/Dizziness
- ☐ Paralysis
- ☐ Numbness/Tingling
- ☐ Loss of Balance
- ☐ Seizures/Epilepsy

26. Endocrine

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

27. Other

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

28. **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? _____

29. **Lifestyle:**

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

How did you hear about us? _____

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