REMEDY HEALING ARTS, LLC
New Patient Health History Form

Appointment Date:

GENERAL INFORMATION

Name: _____ Sex: M / F / T(MTF) / T(FTM) DOB: _____ Age: ____

Street: _____ City: _____ State: _____ Zip: _____

Work #: _____ Home #: _____ Mobile #: _____

Email: _____ Occupation: _____

Single / Married / Partnered / Divorced / Widowed # and Ages of Children: _____

Emergency Contact and #: _____ Relationship: _____

Primary Care Provider and #: _____

Are you presently under a doctor's care? Y / N If yes, for what? _____

Are there any other therapies you are receiving? Y / N If yes, for what? _____

Have you received acupuncture before? Y / N If yes, describe _____

PRIMARY HEALTH COMPLAINT

What is your primary reason for seeking care with us? _____

_____

What was the initial cause? _____

When did it begin? _____

What makes it worse? _____ better? _____

How does it interfere with your daily activities? (circle all that apply):

Work Sleep Walking Sitting Standing Bending Stretching Emotional

Relationships Social Life Recreation Sex Other _____

What have you done about this? _____

What other secondary health complaints do you have? _____

_____

Are you interested in (circle all that apply):

Pain Relief Performance Care Corrective Care Preventative Care Holistic Health

Stress Relief Nutritional Therapy Other _____

What are your health goals? _____

_____

MEDICAL HISTORY

	TYPE	DATE	AGE
Past surgeries/ hospitalizations:			
Future surgeries/ hospitalizations:			
Trauma (Auto-accidents, falls, emotional, sexual):			
Past and Current Exercise/Sports Involvement:			

Allergies:	ALLERGY	AGE @ ONSET	SYMPTOMS/TIME OF YEAR

OTC Drugs:	NAME	WHAT'S IT FOR?	DOSAGE (# per day)	HOW LONG TAKEN?

Prescription Drugs:

NAME	WHAT'S IT FOR?	DOSAGE (# per day)	HOW LONG TAKEN?

Supplements/Herbs:

NAME	WHAT'S IT FOR?	DOSAGE (# per day)	HOW LONG TAKEN?

MEDICAL HISTORY (continued)

Substance Use:

# of alcoholic beverages consumed, on average, per week _____

Have you ever been concerned about your drinking? Yes / No / Not Sure

Has anyone else been concerned about your drinking? Yes / No / Not Sure

cigarettes smoked per day _____ # cigars smoked per day _____

pipes smoked per day _____ # chews per day _____

Age when you first started smoking?_____

Have you ever tried to quit smoking? Yes / No / NA

Are you interested in quitting smoking? Yes / No / NA

If you are a former smoker, how long ago did you quit? _____

Below list any other substances you are using or have used in the past.

SUBSTANCE	LAST USED?	HOW OFTEN USED?	HOW LONG USED?
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Amount of chocolate per day _____ Cups of coffee per day _____

# of sodas per day _____ Cups of tea per day _____

Sleep and Energy:

How many hours of sleep do you get per night? _____ Do you sleep well? Yes / No / Not sure

If no, circle all that applies to your sleep: Trouble Falling Asleep / Trouble Staying Asleep

Do you keep a regular wake/sleep schedule? Yes / No Wake time: _____ Bedtime: _____

On a scale of 1 to 10, with 10 being best, how would you rate your energy level? _____

At what time of the day is your energy highest? _____ lowest? _____

Do you think your energy could be improved? Yes / No / Not sure

Family History:

Circle if you currently have or in the past have had any of the conditions listed below. Underline if any of your family members currently have or in the past have had any of the conditions listed below.

Anemia	Epilepsy/Seizures	High/Low Blood Pressure	Mumps
Arthritis	Gonorrhea/Herpes/Syphilis	Hyper/Hypothyroidism	Multiple Sclerosis
Blood Transfusion	Gout	Jaundice	Obesity
Cancer	Heart Attack/Disease	Kidney Stones	Pneumonia
Diabetes	Hepatitis B	Measles	Premature Gray
Drug Reaction	HIV/AIDS	Mental Illness	TB/Parasites

MEDICAL HISTORY (continued)

Personal:

What are your indulgences? _____

What are your hobbies/pastimes? _____

Female Only:

Date of first menses _____ Date of first day of most recent period _____

Are periods regular? Yes / No / Not sure What is your average cycle length? _____

What is your average period length? _____ Are periods painful? Always / Sometimes / Never

If yes, circle when the pain occurs? Before Period / During Period / After Period

Circle any of the following symptoms experienced before, during, or after your period:

Clotting Heavy bleeding PMS Vaginal pain Vaginal sores

Have you ever been pregnant? Yes / No Live Births: _____ Miscarriages: _____ Abortions: _____

Have you ever had problems getting pregnant? Yes / No

If you are not currently using chemical contraceptives (oral, patch, ring, etc.), have you ever used it in the past? Yes / No

Have you been through menopause? Yes / No If so, date of your final period _____

Are you currently experiencing menopausal symptoms? Yes / No / Not sure

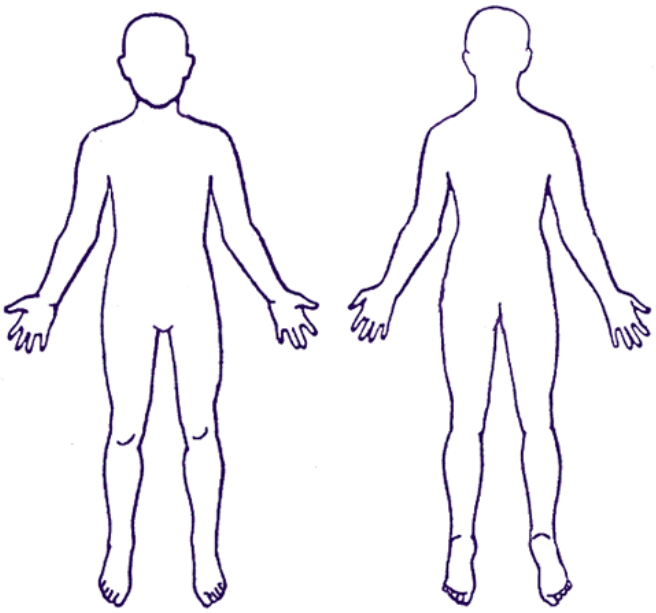
CURRENT SIGNS AND SYMPTOMS

Circle all that you are currently experiencing.

Abdominal pain	Cough	Headache	Migraine	Seeing a therapist
Abdominal distention	Coughing blood	Hemorrhoids	Mouth sores	Shortness of breath
Abuse survivor	Dark stools	Heart palpitations	Mucus in stools	Sinus pain/pressure
Acid reflux	Decreased libido	Hiccups	Muscle cramps/pain	Skin fungal infection
Acne	Depression	High blood pressure	Nasal congestion	Spots in eyes
Asthma	Dizziness/Vertigo	Impotence	Neck/shoulder pain	Sweats easily
Bad breath	Dry throat/mouth	Increased libido	Night sweats	Sore throat
Bloody stool	Diarrhea	Indigestion	Nocturnal emissions	Sudden energy drop
Blood in urine	Earaches	Intestinal pain/cramps	Nosebleeds	Swollen glands
Blurry vision	Enlarged thyroid	Irritability/short temper	Numbness/tingling	Teeth/gum problems
Breast lump/pain	Eye pain/strain/redness	Itchy eyes	Odorous stools	Ulcerations
Bruise easily	Excess phlegm	Itchy skin/rash	Pain upon urination	Upper back pain
Chest pains	Excess saliva	Joint pain	Peculiar tastes	Urgent urination
Chills	Fatigue	Laxative use	Poor appetite	Vomiting
Cold hands/feet	Fever	Limited range of motion	Poor circulation	Wake to urinate
Concussion	Frequent urination	Loss of hair	Poor memory	Weight gain/loss
Confusion	Gas/belching	Low back pain	Premature ejaculation	Wheezing
Constipation	Grinding teeth	Irritability	Psoriasis	

PAIN

Indicate areas of pain including tension, numbness, tingling, and/or discomfort on the chart below.



For each area, circle which best describes your pain.

Intensity Level

None Moderate Severe Terrible

Sleep Disturbance

None Mild Great Cannot sleep

Work Impact

None Some Most Cannot work

Travel Impact – Long Trips

No problem Moderate pain Cannot travel

Recreation Impact

None Some Most Cannot recreate

Walking

None Some Most Cannot walk

Sitting

None Some Most Cannot sit

Frequency of Pain

25% or less 50% or less 75% or less 100% of time

LIFESTYLE HABITS

Diet:

Are you? (circle all that apply): Ovo-Lacto Vegetarian / Vegetarian / Semi-Vegetarian / Pescatarian (fish only)

Do you have any allergies to food? Yes / No If yes, please list _____

Describe the meals and snacks that you eat during a typical day. If you skip meals, please indicate this.

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks/Dessert: _____

How often do you have a bowel movement? More than 3x per day / 1-3x per day / Less than 1x per day

Is your stool typically? (circle all that apply):

Separate hard lumps, like pebbles (hard to pass)
Sausage-shaped, but lumpy
Like a brown banana but with surface cracks
Like a smooth brown banana
Soft blobs with clear cut edges, passed easily
Fluffy pieces with ragged edges, a mushy stool
Watery, no solid pieces. Entirely liquid

Exercise:

Are you? (circle one):

Sedentary (no exercise)
Mild exercise (i.e. climb stairs, walk 3 blocks, golf, etc.)
Occasional vigorous exercise (i.e. work or recreation, less than 4x/week for 30 minutes)
Regular vigorous exercise (i.e. work or recreation, 4x/week or more for 30 minutes)

HEALTH SNAPSHOT

Chinese medicine determines health based on multiple aspects of a person's life, and physical health is only one of these. Only when all areas are in balance can a person be truly be well. Choose your level of satisfaction with each of the health categories below to determine your current overall wellbeing. The finished picture should give you some idea of which aspects of your life need attention in order to improve your level of wellness in the future.

Circle the number that best reflects your health in each category. 10 = very satisfied. 1 = very unsatisfied. For example, if you are extremely satisfied with your social life, then you would circle 10 in that category.

1. Physical Health: 1 2 3 4 5 6 7 8 9 10
2. Mental Health: 1 2 3 4 5 6 7 8 9 10
3. Emotional Health: 1 2 3 4 5 6 7 8 9 10
4. Sexual Health: 1 2 3 4 5 6 7 8 9 10
5. Career Health: 1 2 3 4 5 6 7 8 9 10
6. Financial Health: 1 2 3 4 5 6 7 8 9 10
7. Family Health: 1 2 3 4 5 6 7 8 9 10
8. Social Health: 1 2 3 4 5 6 7 8 9 10

TYPES OF CARE

At Remedy Healing Arts, LLC, we are focused on the wellness and healing of our patients using Chinese medicine including, but not limited to, acupuncture, Chinese medical massage, lifestyle counseling, and whole food supplements along with other modalities. It is important to know that the stages of Chinese medicine care are unique relative to those of other health-care disciplines because Chinese medicine addresses core physiological and biochemical aspects of the body rather than just treating symptoms. We treat the whole person, not individual ailments. Therefore, the process of correcting problems without drugs or surgery can take some time. Your acupuncturist will inform you as to what stage of care you fall into so that together you can work out a plan to meet your health goals.

Our three main areas of focus at Remedy Healing Arts, LLC are relief care, corrective care, and preventative/wellness care.

The following is a brief summary of the three major phases of Chinese medicine care.

Phase 1: Relief Care

Relief care can provide relief of symptoms or pain but cannot eliminate the cause of the symptom or pain. Relief care is not permanent and could be compared to using a bucket to catch a leak in a roof. Number of treatments is dependent upon whether the health condition is acute or chronic.

Phase 2: Corrective Care

Corrective care not only relieves or reduces pain or symptoms, but it also eliminates the actual cause of the problem. Corrective care can be nearly permanent provided that the patient is compliant with home care and lifestyle changes. This type of care could be compared to repairing the shingles on a roof to prevent leaks. Number of treatments is dependent upon whether the health condition is acute or chronic.

Phase 3: Wellness & Preventative Care

Wellness care keeps the patient's body moving toward perfect health. The desire to continue on the path of health enables the body to prevent problems from occurring and continue operating at its optimal functioning level. This type of care is comparable to regularly having your roof inspected for damage and leaks. Number of treatments is usually once or twice per month or even once per quarter.