House Acupuncture & Herbs

New Patient Health History

This is a CONFIDENTIAL health profile to help us determine the best treatment plan for you. If you have any questions, please ask.

Name: ____ Date: ______/______/______

(first) (middle) (last)

Date of Birth: _______/_______/_______ Age: _______ Sex: M F Marital status: S M D W

Home Address: ____

City: ________________________ State:_____ Zip: _________ Email: ______________________

Would you like to receive our email newsletter? Y N

Phone: Home _________________ Cell: __________________ Work:______________________

Preferred mode of contact (circle one): Home # Cell # Work # Email Ok to leave voice message? Y N

Who may we thank for referring you to our office? ____

Emergency Contact: _______________________ Emergency Contact phone: _______________________

Height: _________ Weight: _________

Primary Insurance

Person Responsible for Account____

Relationship to Patient ____________________________Birthdate_____________ Soc. Sec. #_____________

Person Responsible Employed by ____ Occupation ____________

Insurance Company ____

Policy # ______________________________________ Group # __________________________________

Effective Date: _______________ Copay $_______________Deductible $_____________amount met $_______

Insurance type: HMO PPO Workers Comp Auto Other ______________________________

Assignment and Release

I, the undersigned, certify that I (or my dependent) have insurance coverage with (name of insurance company) ___________ and assign directly to Cheryl House, L.Ac. all insurance benefits, if any, otherwise payable to me for services rendered. I hereby authorize release of all information necessary to secure payment of benefits. I understand that if Cheryl House, L.Ac. submits a claim for billed charges to my health plan(s) on my behalf, I am not relieved of my financial responsibility for payment. In the event that the health plan or any third party payor does not pay the entire billed amount, I agree to pay any remaining balance, except as restricted by my health plan.

*Signature:*____*Date:*______________

Successful health care and preventative medicine are only possible when the practitioner has a complete understanding of the patient physically, mentally, and emotionally. Please complete this questionnaire as thoroughly as possible. Print all information and indicate areas of confusion with a question mark. Thank you.

Have you seen a physician in the last year? Yes No Reason: ___________________________________

Physician Name: _______________________ Phone: ____________________________________

Please indicate if any of the following statements are true:

- I have known allergies: Y N To what? ________________
- I have a pacemaker: Y N
- I am pregnant: Y N How many weeks? _________
- I am currently trying to get pregnant: Y N
- I am taking Coumadin/ Warfarin/or Plavix: Y N
- I am taking lithium (Eskalith, Lithonate, Lithotabs): Y N

What is your primary health complaint?

____

____

Do you have any additional health concerns?

____

Medications: Please list any prescription of Over the Counter medications you are currently taking:

Prescription	Dosage	Reason for taking	Prescribed by

Supplements: Please list any vitamins, herbs, or supplements you are currently taking

Supplement	Dosage	Reason for taking	Prescribed by

Family History:

Check if applicable	Father	Mother	Brothers	Sisters	Children
Age (if living)	______	______	______	______	______
Health (G=Good, P=Poor)	______	______	______	______	______
Cancer	______	______	______	______	______
Diabetes	______	______	______	______	______
Heart Disease	______	______	______	______	______
High Blood Pressure	______	______	______	______	______
Stroke	______	______	______	______	______
Mental Illness	______	______	______	______	______
Asthma/Allergies	______	______	______	______	______
Kidney Disease	______	______	______	______	______
Age (at death)	______	______	______	______	______
Cause of Death	______	______	______	______	______

Childhood Illness (please circle any that you have had):

Scarlet Fever Diphtheria Rheumatic Fever Mumps Measles German Measles Chicken Pox

Immunizations (please circle any that you have had):

Polio Tetanus Rubella/Mumps/Rubella Pertussis Diphtheria Hepatitis B HPV

Others: ____

Hospitalizations and Surgeries:

Reason	When	Reason	When

X-Rays/CAT Scans/MRI's/NMR's/Special Studies:

Reason	When	Reason	When

Energy and Immunity (please circle any that you experience now and underline any that you have experienced in the past):

Fatigue Slow Wound Healing Chronic Infections Chronic Fatigue Syndrome

Head, Eye, Ear, Nose, and Throat (please circle any that you experience now and underline any that you have experienced in the past):

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

Respiratory

Pneumonia	Frequent Colds/Flus	Difficulty Breathing	Emphysema
Persistent Cough	Allergies	Asthma	Tuberculosis
Shortness of Breath	Other: ______________________________		

Cardiovascular

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

Gastrointestinal

Ulcers | Changes in Appetite | Nausea/Vomiting | IBS | Passing Gas | Heartburn
Belching | Gall Bladder Disease | Liver Disease | Hepatitis B or C | Hemorrhoids | Abdominal Pain

Genito-Urinary Tract

Kidney Disease | Painful Urination | Frequent UTI | Frequent Urination | Cloudy urination
Kidney Stones | Impaired Urination | Blood in Urine | Urination at Night | Incontinence

Female Reproductive/Breasts

Irregular Cycles | Breast Lumps/Tenderness | Nipple Discharge | Heavy Periods
Vaginal Discharge | PMS | Clotting | Bleeding Between Cycles
Menopausal Symptoms | Difficulty Conceiving | Painful Periods | Low Libido
Vaginal Dryness | Other: _______________

Menstrual/Birthing History:

1. Age of First Menses: _______
2. # of Days of Menses: _______
3. Length of Cycle: _______
4. Method of Birth Control: ________
5. # of Pregnancies: ________
6. # of Miscarriages: ________
7. # of Abortions: ________
8. # of Live Births: ________

Male Reproductive

Erectile Dysfunction | Urinary/Prostate problems | Testicular Pain/Swelling | Penile Discharge
Low Libido | Other:________________

Musculoskeletal

Neck/Shoulder Pain | Muscle Spasms/Cramps | Arm Pain | Upper Back Pain | Mid Back Pain
Low Back Pain | Leg Pain | Osteoporosis | Arthritis/Joint Pain - where?________

Neurologic:

Vertigo/Dizziness | Paralysis | Numbness/Tingling | Loss of Balance | Seizures/Epilepsy

Endocrine

Hypothyroid | Hypoglycemia | Hyperthyroid | Diabetes Mellitus | Night Sweats | Feeling Hot or Cold

Mental/Emotional

Mood Swings | Anxiety | Irritability | Depression | Schizophrenia
Other:____

Other

Anemia | Insomnia | Cancer | Rashes | Eczema/Hives | Cold Hands/Feet
Other:____

Lifestyle:

How would you rate your quality of life? Excellent Good OK Fair Poor
Exercise routine: ____
How many hours per night do you sleep? ________ Do you wake rested? Y N
Level of education completed: High School Bachelors Masters Doctorate Other
Occupation: ______________________ Employer: ____________ Hours/Week: _______
Do you enjoy work? Y/N Why/Why not? ________________________________
Do you smoke? Y N # per day _____________ for ______________ years Recreational Drugs _________________
Cups coffee/tea per day _______________ # Alcoholic drinks _____________ #Soda/Diet soda ___________