Muriel Okubo, Registered Acupuncturist
Patient Health History

Name: _____ Date: _____/_____/_____
(first) (middle) (last) month day year

Date of Birth: _____/_____/_____ Age: _____ Gender: M / F Marital status: S M D W
month day year

Address: _____ City: _____ Province: _____ Postal Code: _____

Telephone: Home _____ Work _____ Cell _____

Email address: _____ Fax: _____

In case of emergency, call _____ Phone: _____ Relationship _____

Family physician: _____ Phone: _____

Occupation: _____ Employer: _____

How did you hear about us? _____

Referred by: _____

Successful health care and preventative medicine is effective 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.

1. When and where did you last receive health care? _____

For what reason? _____

2. What (if any) medical diagnoses have you received? _____

Are you receiving (or received) any treatments? _____

3. Please identify the health concerns that have brought you to the Clinic in order of importance below:

Condition	**When Did It Start?**	**Past Treatment**
a. _____	_____	
b. _____	_____	
c. _____	_____	

4. If female, do you have any reason to believe you may be pregnant? Y N

If so, how far along are you? _____

5. If applicable, please list any foods, drugs, or medications you are hypersensitive or allergic to (please include reaction):

_____

6. Please list any medications (prescribed and over-the-counter), vitamins, and supplements you are currently taking and their dosage:

_____

7. Please check any of the following medications that you are currently taking:

- ☐ Laxatives
- ☐ Pain Relievers
- ☐ Antacids
- ☐ Thyroid Medication
- ☐ Appetite Suppressants
- ☐ Antibiotics
- ☐ Tranquilizers
- ☐ Sleeping Pills
- ☐ Cortisone
- ☐ Blood Pressure Medication

8. Do you have any chronic infectious diseases? Y N If yes, please identify: _____

9. Are you currently suffering from any chronic illnesses? Y N

If yes, please explain:_____

10. **Height:** _____**Weight:** Currently: _____ Past Maximum: _____ When? _____

11. **Blood Pressure:** What is your most recent blood pressure reading? _____ /_____ When was this reading taken? _____/_____/_____
month day year

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

- ☐ Scarlet Fever
- ☐ Diphtheria
- ☐ Rheumatic Fever
- ☐ Mumps
- ☐ Measles
- ☐ German Measles
- ☐ Chicken Pox

13. **Immunizations** (please circle any that you have had):

- ☐ Polio
- ☐ Tetanus
- ☐ Measles/Mumps/Rubella
- ☐ Pertussis
- ☐ Diphtheria
- ☐ Hepatitis B

14. **Hospitalizations and Surgeries** (please list as best you can):

Reason and when _____

Reason and when_____

Reason and when_____

Reason and when_____

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

Reason and when_____

Reason and when_____

Reason and when_____

Reason and when_____

16. **Family History:**	Father	Mother	Brothers	Sisters	Spouse	Children
Check those applicable:						
Age (if living)	_____	_____	_____	_____	_____	_____
Health (G=Good, P=Poor)	_____	_____	_____	_____	_____	_____
Age at death (if deceased)	_____	_____	_____	_____	_____	_____
Cause of Death:	_____	_____	_____	_____	_____	_____

✓ *Check any conditions that members of your family have had below:*

Cancer	_____	_____	_____	_____	_____	_____
Diabetes	_____	_____	_____	_____	_____	_____
Heart Disease	_____	_____	_____	_____	_____	_____
High Blood Pressure	_____	_____	_____	_____	_____	_____
Stroke	_____	_____	_____	_____	_____	_____
Mental Illness	_____	_____	_____	_____	_____	_____
Asthma/Hay fever/Hives	_____	_____	_____	_____	_____	_____
Kidney Disease	_____	_____	_____	_____	_____	_____

Please check any that you experience now and underline any that you have experienced in the past. Feel free to write anything extra you feel is important.

17. TEMPERATURE

- ☐ Cold hands/ feet
- ☐ Chills
- ☐ Cold "from inside"
- ☐ Feverish
- ☐ Alternating fever/ chills
- ☐ Hot hands, feet, chest
- ☐ Hot flashes
- ☐ Hot at night
- ☐ Hot in day

18. SWEATING

- ☐ Spontaneous sweating – unusual
  Location: _____
- ☐ Night sweats _____

19. THIRST

- ☐ Thirst: cold or hot drinks
- ☐ Thirst: no desire to drink
- ☐ Absence of thirst
- ☐ Excessive thirst

20. SKIN DRYNESS

- ☐ Dry skin
- ☐ Dry hair
- ☐ Dry nails
- ☐ Dandruff
- ☐ Dry mouth
- ☐ Dry lips
- ☐ Dry nose
- ☐ Itchiness

21. MOISTURE

- ☐ Oily skin
- ☐ Oily hair
- ☐ Pimples

22. HEADACHES

- ☐ Headaches
- ☐ Dizziness
- ☐ Vertigo
- ☐ Light-headedness

23. EARS, EYES, NOSE & THROAT

- ☐ Poor vision
- ☐ Blurry vision
- ☐ Red eyes
- ☐ Dry eyes
- ☐ Itchy eyes
- ☐ Floaters/ spots
- ☐ Eye pain/ strain
- ☐ Ringing ears
- ☐ Impaired hearing
- ☐ Ear pain/ ache
- ☐ Phlegm
- ☐ Runny nose
- ☐ Sinus congestion
- ☐ Nose bleeds
- ☐ Sore throat
- ☐ Dry throat
- ☐ Difficult swallowing
- ☐ Mouth sores / canker
- ☐ Facial palsy
- ☐ TMJ/ Jaw problems
- ☐ Teeth grinding

24. HEART/ LUNGS

- ☐ Palpitations
- ☐ Chest pain
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Chest tightness
- ☐ Swelling of ankles
- ☐ Heat disease
- ☐ Shortness of breath
- ☐ Frequent common colds
- ☐ Difficulty breathing
- ☐ Persistent coughing
- ☐ Allergies
- ☐ Hay- fever
- ☐ Asthma
- ☐ Other respiratory problems:
  _____
  _____
  _____

25. APPETITE

- ☐ No hunger
- ☐ Poor appetite
- ☐ Hungry, but dislike eating
- ☐ Excessive hunger
- ☐ Changes in appetite

26. GI/ DIGESTION

- ☐ Passing gas
- ☐ Belching
- ☐ Bloating
- ☐ Nausea/ Vomiting
- ☐ Stomach pain
- ☐ Ulcers
- ☐ Heartburn/ acid reflux
- ☐ Bad Breath
- ☐ Liver Disease
- ☐ Hepatitis B or C
- ☐ Gall bladder disease
- ☐ Hemorrhoids

Please check any that you experience now and underline any that you have experienced in the past. Feel free to write anything extra you feel is important.

27. BOWEL MOVEMENTS (BM)

- ☐ Constipation
- ☐ Difficult to pass
- ☐ Blood in stools
- ☐ Alternating diarrhea & constipation
- ☐ Tired after BM
- ☐ Loose stools
- ☐ Diarrhea
- ☐ Undigested food
- ☐ Pain during BM
- ☐ Gaseous BM
- ☐ Mucous in stool
- ☐ Foul-smelling stools

28. URINATION

- ☐ Frequent urination
- ☐ Urgent urination
- ☐ Painful urination
- ☐ Dribbling urination
- ☐ Burning sensation
- ☐ Blood in urine
- ☐ Incontinence
- ☐ Urinary tract infection
- ☐ Cloudy urine
- ☐ Kidney stones
- ☐ Decreased output
- ☐ Weak urine stream
- ☐ Kidney disease

29. ENERGY & IMMUNITY

- ☐ Low energy
- ☐ Tired after eating
- ☐ Energy level scale: _____ (10 being best)
- ☐ Poor wound healing

30. MEMORY/ CONCENTRATION

- ☐ Poor memory
- ☐ Confusion
- ☐ Difficulty concentrating
- ☐ Racing thoughts

31. EMOTIONS

- ☐ Anger
- ☐ Depression
- ☐ Irritability
- ☐ Frequent Sighing
- ☐ Anxiety
- ☐ Joy
- ☐ Panic Attacks
- ☐ Fear/ fright
- ☐ Worry
- ☐ Over-thinking
- ☐ Sadness
- ☐ Grief
- ☐ Timid/ Shy
- ☐ Indecision

32. SLEEP

How is your sleep? _____.
Do you feel rested? _____.
How many hours of sleep do you get? _____
Time you go to sleep? _____
Time you get up? _____

Any difficulty:

- ☐ Falling asleep
- ☐ Staying asleep
- ☐ Dream-disturbed sleep
- ☐ Waking to urinate # of times
- ☐ Waking up and then trouble falling back asleep

33. NEUROLOGIC

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

Please check any that you experience now and underline any that you have experienced in the past. Feel free to write anything extra you feel is important

34. FEMALE REPRODUCTIVE

- ☐ Irregular periods
- ☐ Heavy periods
- ☐ Light periods
- ☐ No periods
- ☐ Breast lumps/ tenderness
- ☐ Nipple discharge
- ☐ Vaginal discharge
- ☐ PMS/ mood
- ☐ Clots
- ☐ Bleeding between cycles/ spotting
- ☐ Cramps
- ☐ Menopausal symptoms
- ☐ Difficulty conceiving
- ☐ Painful periods
- ☐ Low sex drive
- ☐ Vaginal dryness/ itching

Menstrual/ Birthing History

1. Age of first menses: _____
2. # of days of menses: _____
3. Length of cycle: _____
4. Birth control type: _____
   _____
5. # of pregnancies: _____
6. # of miscarriages: _____
7. # of abortions: _____
8. # of live births: _____
9. Menopause: _____

35. MALE REPRODUCTIVE

- ☐ Change in sex drive
- ☐ Erectile dysfunction
- ☐ Premature ejaculation
- ☐ Penile discharge
- ☐ Hernia
- ☐ Hemorrhoids
- ☐ Enlarged prostate
- ☐ Sexual difficulties
- ☐ Testicular pain/ swelling

36. BODY PAIN

Musculoskeletal

- ☐ Neck/ shoulder pain
- ☐ Muscle spasms/ cramps
- ☐ Arm pain
- ☐ Upper back pain
- ☐ Mid back pain
- ☐ Lower back pain
- ☐ Leg pain
- ☐ Joint pain (if so, where?): _____

Pain Description

- ☐ Sharp
- ☐ Dull
- ☐ Numbness
- ☐ Fixed pain
- ☐ Stabbing
- ☐ Achy
- ☐ Tingling
- ☐ Wandering pain
- ☐ Constant
- ☐ Comes and goes
- ☐ Pins/ needles

37. OTHER

- ☐ Anemia
- ☐ Cancer
- ☐ Rashes
- ☐ Eczema/ Hives
- ☐ Diabetes Mellitus
- ☐ Stroke
- ☐ Hypothyroid
- ☐ Hypoglycemia
- ☐ Hyperthyroid
- ☐ Heart Murmurs

Is there anything else you feel I should know?

_____

_____

38. Lifestyle:

a. Do you typically eat at least three meals per day? Y N If no, how many? _____

Please indicate typical food intake:

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

Food Cravings: Sweet Salty Bland Bitter Spicy Sour Greasy

Do you eat animal products: _____

b. Exercise routine: _____

c. Spiritual practice: _____

d. Have you experienced any major traumas? Y N Explain:

_____

_____

e. Are you in a relationship? _____ How do you feel about it? _____

f. Level of education completed: High School Bachelors Masters Doctorate Other

Do you enjoy your work? _____

Why or why not _____

g. Do you smoke? _____ Heavy/ Light _____

h. How much alcohol do you consume? _____

i. Caffeinated beverages? _____

j. How many glasses of non-caffeinated, non-carbonated beverages do you drink per day? _____

k. Television habits: _____ Reading habits: _____

l. Interests and hobbies: _____

m. Are you interested in: ___ Pain Relief ___ Performance Care ___ Maintenance
___ Preventive Care ___ Holistic Health ___ Stress Relief
___ Oriental Nutrition ___ Shiatsu Therapy ___ Herbal Therapy

What are your health goals?