

## 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:

<u>Condition</u>	<u>When Did It Start?</u>	<u>Past Treatment</u>
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:

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Laxatives          | <input type="checkbox"/> Appetite Suppressants | <input type="checkbox"/> Cortisone                 |
| <input type="checkbox"/> Pain Relievers     | <input type="checkbox"/> Antibiotics           | <input type="checkbox"/> Blood Pressure Medication |
| <input type="checkbox"/> Antacids           | <input type="checkbox"/> Tranquilizers         |  |
| <input type="checkbox"/> Thyroid Medication | <input type="checkbox"/> Sleeping Pills        |  |

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):

- |  |   |
|--|---|
| <input type="checkbox"/> Scarlet Fever   | <input type="checkbox"/> Measles        |
| <input type="checkbox"/> Diphtheria      | <input type="checkbox"/> German Measles |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Chicken Pox    |
| <input type="checkbox"/> Mumps           |   |

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

- |  |                                      |
|--|--------------------------------------|
| <input type="checkbox"/> Polio                 | <input type="checkbox"/> Pertussis   |
| <input type="checkbox"/> Tetanus               | <input type="checkbox"/> Diphtheria  |
| <input type="checkbox"/> Measles/Mumps/Rubella | <input type="checkbox"/> 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)

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Constipation                        | <input type="checkbox"/> Tired after BM  | <input type="checkbox"/> Pain during BM       |
| <input type="checkbox"/> Difficult to pass                   | <input type="checkbox"/> Loose stools    | <input type="checkbox"/> Gaseous BM           |
| <input type="checkbox"/> Blood in stools                     | <input type="checkbox"/> Diarrhea        | <input type="checkbox"/> Mucous in stool      |
| <input type="checkbox"/> Alternating diarrhea & constipation | <input type="checkbox"/> Undigested food | <input type="checkbox"/> Foul-smelling stools |

### 28. URINATION

- |  |  |  |  |
|--|--|--|--|
| <input type="checkbox"/> Frequent urination  | <input type="checkbox"/> Burning sensation | <input type="checkbox"/> Urinary tract infection | <input type="checkbox"/> Decreased output  |
| <input type="checkbox"/> Urgent urination    | <input type="checkbox"/> Blood in urine    | <input type="checkbox"/> Cloudy urine            | <input type="checkbox"/> Weak urine stream |
| <input type="checkbox"/> Painful urination   | <input type="checkbox"/> Incontinence      | <input type="checkbox"/> Kidney stones           | <input type="checkbox"/> Kidney disease    |
| <input type="checkbox"/> Dribbling urination |  |  |  |

### 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

- |   |  |  |                                     |
|---|--|--|-------------------------------------|
| <input type="checkbox"/> Anger            | <input type="checkbox"/> Anxiety       | <input type="checkbox"/> Worry         | <input type="checkbox"/> Grief      |
| <input type="checkbox"/> Depression       | <input type="checkbox"/> Joy           | <input type="checkbox"/> Over-thinking | <input type="checkbox"/> Timid/ Shy |
| <input type="checkbox"/> Irritability     | <input type="checkbox"/> Panic Attacks | <input type="checkbox"/> Sadness       | <input type="checkbox"/> Indecision |
| <input type="checkbox"/> Frequent Sighing | <input type="checkbox"/> Fear/ fright  |  |                                     |

### 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:**

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Falling asleep | <input type="checkbox"/> Dream-disturbed sleep        | <input type="checkbox"/> Waking up and then trouble falling back asleep |
| <input type="checkbox"/> Staying asleep | <input type="checkbox"/> Waking to urinate # of times |   |

### 33. NEUROLOGIC

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Vertigo/ Dizziness | <input type="checkbox"/> Numbness/ Tingling | <input type="checkbox"/> Seizures/ Epilepsy |
| <input type="checkbox"/> Paralysis          | <input type="checkbox"/> Loss of Balance    |   |

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

- |   |  |
|---|--|
| <input type="checkbox"/> Irregular periods        | <input type="checkbox"/> Clots                             |
| <input type="checkbox"/> Heavy periods            | <input type="checkbox"/> Bleeding between cycles/ spotting |
| <input type="checkbox"/> Light periods            | <input type="checkbox"/> Cramps                            |
| <input type="checkbox"/> No periods               | <input type="checkbox"/> Menopausal symptoms               |
| <input type="checkbox"/> Breast lumps/ tenderness | <input type="checkbox"/> Difficulty conceiving             |
| <input type="checkbox"/> Nipple discharge         | <input type="checkbox"/> Painful periods                   |
| <input type="checkbox"/> Vaginal discharge        | <input type="checkbox"/> Low sex drive                     |
| <input type="checkbox"/> PMS/ mood                | <input type="checkbox"/> Vaginal dryness/ itching          |

#### Menstrual/ Birthina History

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

### 35. MALE REPRODUCTIVE

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Change in sex drive   | <input type="checkbox"/> Penile discharge | <input type="checkbox"/> Enlarged prostate         |
| <input type="checkbox"/> Erectile dysfunction  | <input type="checkbox"/> Hernia           | <input type="checkbox"/> Sexual difficulties       |
| <input type="checkbox"/> Premature ejaculation | <input type="checkbox"/> Hemorrhoids      | <input type="checkbox"/> Testicular pain/ swelling |

### 36. BODY PAIN

#### Musculoskeletal

- |  |  |
|--|--|
| <input type="checkbox"/> Neck/ shoulder pain   | <input type="checkbox"/> Mid back pain                     |
| <input type="checkbox"/> Muscle spasms/ cramps | <input type="checkbox"/> Lower back pain                   |
| <input type="checkbox"/> Arm pain              | <input type="checkbox"/> Leg pain                          |
| <input type="checkbox"/> Upper back pain       | <input type="checkbox"/> Joint pain (if so, where?): _____ |

#### Pain Description

- |                                     |   |   |
|-------------------------------------|---|---|
| <input type="checkbox"/> Sharp      | <input type="checkbox"/> Stabbing       | <input type="checkbox"/> Constant       |
| <input type="checkbox"/> Dull       | <input type="checkbox"/> Achy           | <input type="checkbox"/> Comes and goes |
| <input type="checkbox"/> Numbness   | <input type="checkbox"/> Tingling       | <input type="checkbox"/> Pins/ needles  |
| <input type="checkbox"/> Fixed pain | <input type="checkbox"/> Wandering pain |   |

### 37. OTHER

- |  |  |
|--|--|
| <input type="checkbox"/> Anemia            | <input type="checkbox"/> Stroke        |
| <input type="checkbox"/> Cancer            | <input type="checkbox"/> Hypothyroid   |
| <input type="checkbox"/> Rashes            | <input type="checkbox"/> Hypoglycemia  |
| <input type="checkbox"/> Eczema/ Hives     | <input type="checkbox"/> Hyperthyroid  |
| <input type="checkbox"/> Diabetes Mellitus | <input type="checkbox"/> 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?