Life Gate Acupuncture

Patient Health History

Name _____ **Date of Birth** _____

Street Address _____

City _____ **State** _____ **Zip Code** _____

CHIEF COMPLAINT:

What is you primary reason for the visit?

When did your symptoms first begin?

How often are your symptoms present?

What aggravates this condition?

What alleviates this condition?

What treatments have you tried for this condition?

Please list all current medications and supplements are affecting your health:

MEDICAL HISTORY:

General
- ☐ Chills
- ☐ Depression
- ☐ Dizziness
- ☐ Fainting
- ☐ Fever
- ☐ Forgetfulness
- ☐ Headache
- ☐ Loss of Sleep
- ☐ Loss of weight
- ☐ Nervousness
- ☐ Sweats

Muscle/Joint/Bone

Pain, weakness, numbness in:
- ☐ Arms ☐ Hips
- ☐ Back ☐ Legs
- ☐ Feet ☐ Neck
- ☐ Hands ☐ Shoulders

Skin
- ☐ Bruise Easily ☐ Rash
- ☐ Hives ☐ Nonhealing Sores
- ☐ Itching ☐ Varicose Veins

Gastrointestinal
- ☐ Appetite poor
- ☐ Bloating
- ☐ Bowel Changes
- ☐ Constipation
- ☐ Diarrhea
- ☐ Excessive Hunger
- ☐ Excessive Thirst
- ☐ Gas
- ☐ Hemorrhoids
- ☐ Indigestion/Reflux
- ☐ Nausea
- ☐ Rectal Bleeding
- ☐ Stomach Pain☐ Vomiting
- ☐ Vomiting Blood
- ☐ Vision-Flashes
- ☐ Vision-Halos

Cardiovascular
- ☐ Chest Pain
- ☐High Blood Pressure
- ☐ Poor Circulation
- ☐ Swelling of ankle
- ☐ Irregular Heartbeat
- ☐ Low Blood Pressure
- ☐ Rapid heartbeat

Eye, Ear, Nose, Throat
- ☐ Bleeding Gums
- ☐ Blurred Vision
- ☐ Crossed Eyes
- ☐ Difficulty Swallowing
- ☐ Double Vision
- ☐ Earache
- ☐ Ear discharge
- ☐ Hay Fever
- ☐ Hoarseness
- ☐ Loss of Hearing
- ☐ Nosebleeds
- ☐ Persistent Cough
- ☐ Ringing in ears
- ☐ Sinus Problems
- ☐ Other

Genito/Urinary/Gyn/Andro/Sexual Health
- ☐ Breast Lump
- ☐ Erectile dysfunction
- ☐ Lump in testicles
- ☐ Genital discharge
- ☐ Sore on Genitals
- ☐ Painful intercourse
- ☐ Abnormal Pap Smear
- ☐ Bleeding between periods
- ☐ Breast Lump
- ☐ Extreme menstrual pain
- ☐ Hot flashes
- ☐ Nipple discharge
- ☐ Other
- ☐ Blood in Urine
- ☐ Frequent Urination
- ☐ Lack of bladder control
- ☐ Painful urination
- ☐ Frequent Infections: ☐Yeast ☐UTI ☐vaginosis
- ☐ Low Libido

Conditions

Past	Present		Past	Present		Past	Present		Past	Present	
☐	☐	AIDS	☐	☐	Chemical Dependency	☐	☐	High Cholesterol	☐	☐	Prostate Problem
☐	☐	Alcoholism	☐	☐	Chicken Pox	☐	☐	HIV Positive	☐	☐	Psychiatric Care
☐	☐	Anemia	☐	☐	Diabetes	☐	☐	Kidney Disease	☐	☐	Rheumatic Fever
☐	☐	Anorexia	☐	☐	Emphysema	☐	☐	Liver Disease	☐	☐	Scarlet Fever
☐	☐	Appendicitis	☐	☐	Epilepsy	☐	☐	Measles	☐	☐	Stroke
☐	☐	Arthritis	☐	☐	Glaucoma	☐	☐	Migraine Headaches	☐	☐	Suicide Attempt
☐	☐	Asthma	☐	☐	Goiter	☐	☐	Miscarriage	☐	☐	Thyroid Attempts
☐	☐	Bleeding Disorders	☐	☐	Gonorrhea	☐	☐	Mononucleosis	☐	☐	Tonsillitis
☐	☐	Breast Lump	☐	☐	Gout	☐	☐	Multiple Sclerosis	☐	☐	Tuberculosis
☐	☐	Bronchitis	☐	☐	Heart Disease	☐	☐	Mumps	☐	☐	Typhoid Fever
☐	☐	Bulimia	☐	☐	Hepatitis	☐	☐	Pacemaker	☐	☐	Ulcers
☐	☐	Cancer	☐	☐	Hernia	☐	☐	Pneumonia	☐	☐	Vaginal Infections
☐	☐	Cataracts	☐	☐	Herpes	☐	☐	Polio	☐	☐	Venereal Disease

Are you currently pregnant? ☐ Yes ☐ No

Date of Last Menstrual Period: _____

Length of Typical Menstrual Cycle (e.g. 28 days) _____

Length of typical flow (e.g. 4 days)_____

Around your period, do you experience:

- ☐ Clots
- ☐ Cramps
- ☐ PMS
- ☐ Digestive Discomfort
- ☐ Fatigue

Do you use birth control? If so please describe:

Age of first period

Number of pregnancies/outcomes_____

Age of menopause (if applicable)_____ Bleeding since? ☐ Yes ☐ No

Do you use any of the following substances?

- ☐ Coffee
- ☐ Alcohol
- ☐ Cigarettes/tobacco
- ☐ Marijuana
- ☐ Cocaine or other opioids
- ☐ Methamphetamines
- ☐ Other

Please list and explain any allergies or sensitivities:

Please list any implants, joint replacements, heart pacemakers or other devices:

Please list any serious illness, past surgeries, or hospitalizations:

Family History: Please list any significant illness such as bleeding, diabetes, cancer, alcoholism, obesity, heart disease, allergy, epilepsy, high blood pressure, mental illness, stroke etc.....

Mother

Father

Siblings

Children

LIFESTYLE:

Are you active on a regular basis? ☐ Yes ☐ No

If yes, what type of activity and how often?

How much does stress affect your life on a scale of 1-10? (10=extreme stress)

What are the current major stressors in your life?

How do you manage your stress?

What brings you joy in life?

Tell me about your community/support system.

What are your goals for your health?

What is your level of commitment to improving health: 0-10 (10=100% committed)

Certification

I certify that the information that I have given above is correct and accurate to the best of my knowledge.

Patient name: _____ Signature_____