

**Mindful Harmony Acupuncture  
Patient Health History**

Name: \_\_\_\_\_  
(first) (middle) (last)

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_\_ Gender: M/F Marital status: S M D W

*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.*

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

For what reason? \_\_\_\_\_

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

**Condition**

**Past Treatment**

a. \_\_\_\_\_

How does this condition affect you? \_\_\_\_\_

b. \_\_\_\_\_

How does this condition affect you? \_\_\_\_\_

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

\_\_\_\_\_  
\_\_\_\_\_

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

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

5. Do you have any reason to believe you may be pregnant? Y N

If so, how far along are you? \_\_\_\_\_

6. Do you have any infectious diseases? Y N If yes, please identify: \_\_\_\_\_

<b>7. Family History:</b>	<u>Father</u>	<u>Mother</u>	<u>Brothers</u>	<u>Sisters</u>	<u>Spouse</u>	<u>Children</u>
Check those applicable:						
Age (if living)	_____	_____	_____	_____	_____	_____
Health (G=Good, P=Poor)	_____	_____	_____	_____	_____	_____
Cancer	_____	_____	_____	_____	_____	_____
Diabetes	_____	_____	_____	_____	_____	_____
Heart Disease	_____	_____	_____	_____	_____	_____
High Blood Pressure	_____	_____	_____	_____	_____	_____
Stroke	_____	_____	_____	_____	_____	_____
Mental Illness	_____	_____	_____	_____	_____	_____
Asthma/Hay fever/Hives	_____	_____	_____	_____	_____	_____
Kidney Disease	_____	_____	_____	_____	_____	_____
Age (at death)	_____	_____	_____	_____	_____	_____
Cause of Death	_____	_____	_____	_____	_____	_____

8. **Height:** \_\_\_\_\_ **Weight:** Currently: \_\_\_\_\_ Past Maximum: \_\_\_\_\_ When? \_\_\_\_\_

9. **Blood Pressure:** What is your most recent blood pressure reading? \_\_\_\_\_/\_\_\_\_\_ When was this reading taken? \_\_\_\_\_

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

Scarlet Fever    Diphtheria    Rheumatic Fever    Mumps    Measles    German Measles    Chicken Pox

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

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

Others: \_\_\_\_\_

12. **Hospitalizations and Surgeries:**

<u>Reason</u>	<u>When</u>	<u>Reason</u>	<u>When</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

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

<u>Reason</u>	<u>When</u>	<u>Reason</u>	<u>When</u>
_____	_____	_____	_____
_____	_____	_____	_____

Please Circle All That You are CURRENTLY Experiencing

14. **Emotional:**

Mood Swings    Nervousness    Mental Tension    Irritability    Depression    Anxiety    Sadness

15. **Energy and Immunity:**

Fatigue    Slow Wound Healing    Chronic Infections    Chronic Fatigue Syndrome

16. **Head, Eye, Ear, Nose, and Throat:**

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

17. **Respiratory:**

Pneumonia    Frequent Common Colds    Difficulty Breathing    Emphysema

Persistent Cough    Pleurisy    Asthma    Tuberculosis

Shortness of Breath    Other Respiratory Problems: \_\_\_\_\_

18. **Cardiovascular:**

Heart Disease    Chest Pain    Swelling of Ankles    High Blood Pressure

Palpitations/Fluttering    Stroke    Heart Murmurs    Rheumatic Fever    Varicose Veins

19. **Gastrointestinal:**

Ulcers    Changes in Appetite    Nausea/Vomiting    Epigastric Pain    Passing Gas    Heartburn

Belching    Gall Bladder Disease    Liver Disease    Hepatitis B or C    Hemorrhoids    Abdominal Pain

20. **Genito-Urinary Tract:**

Kidney Disease    Painful Urination    Frequent UTI    Frequent Urination    Heavy Flow

Kidney Stones    Impaired Urination    Blood in Urine    Frequent Urination at Night

21. **Female Reproductive/Breasts:**

Irregular Cycles    Breast Lumps/Tenderness    Nipple Discharge    Heavy Flow

Vaginal Discharge    Premenstrual Problems    Clotting    Bleeding Between Cycles

Menopausal Symptoms    Difficulty Conceiving    Painful Periods

22. **Menstrual/Birthing History:**

1. Age of First Menses: \_\_\_\_\_    4. Birth Control Type: \_\_\_\_\_    7. # of Abortions: \_\_\_\_\_

# of Days of Menses: \_\_\_\_\_    5. # of Pregnancies: \_\_\_\_\_    8. # of Live Births: \_\_\_\_\_

3. Length of Cycle: \_\_\_\_\_    6. # of Miscarriages: \_\_\_\_\_

23. **Male Reproductive:**

Sexual Difficulties      Prostrate Problems      Testicular Pain/Swelling      Penile Discharge

24. **Musculoskeletal:**

Neck/Shoulder Pain      Muscle Spasms/Cramps      Arm Pain      Upper Back Pain      Mid Back Pain  
Low Back Pain      Leg Pain      Joint Pain (if so, where?): \_\_\_\_\_

25. **Neurologic:**

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

26. **Endocrine:**

Hypothyroid      Hypoglycemia      Hyperthyroid      Diabetes Mellitus      Night Sweats      Feeling Hot or Cold

27. **Other:**

Anemia      Cancer      Rashes      Eczema/Hives      Cold Hands/Feet

Is there anything else we should know? \_\_\_\_\_  
\_\_\_\_\_

28. **Lifestyle:**

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

b. Exercise routine: \_\_\_\_\_

c. Spiritual practice: \_\_\_\_\_

d. How many hours per night do you sleep? \_\_\_\_\_      Do you wake rested?      Y      N

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

f. Occupation: \_\_\_\_\_      Employer: \_\_\_\_\_      Hours/Week: \_\_\_\_\_

Do you enjoy work?      Y/N      Why/Why not? \_\_\_\_\_

g. Nicotine/Alcohol/Caffeine Use: \_\_\_\_\_

h. Have you experienced any major traumas?      Y      N      Explain: \_\_\_\_\_  
\_\_\_\_\_

i. How many glasses of non-caffeinated, non-carbonated beverages do you drink per day? \_\_\_\_\_

j. Television habits: \_\_\_\_\_      Reading habits: \_\_\_\_\_

k. Interests and hobbies: \_\_\_\_\_

How did you hear about us? _____
Would you like to receive our email newsletter? _____