

Anamaya Wellness Patient Health History

Please take the time to carefully fill out the following questionnaire. The information you provide will help to provide a complete evaluation and better assist in creating a wellness plan uniquely tailored to you.

PATIENT INFORMATION

Today's Date _____

Name _____

Home Address _____ City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____

Email _____ Date of Birth _____

What is the best way to contact you? _____

Family Physician _____ Phone _____

Sex: Male ___ Female ___ Height _____ Weight _____

Marital Status: (please circle) Married/Single/Divorced/Separated/Widowed/Partnered

Who can we thank for referring you? _____

Have you received previous acupuncture? Yes No When? _____ With whom? _____

Emergency Contact _____

Phone _____ Relationship _____

WHAT BRINGS YOU HERE

What health concerns bring you into our office for treatment? _____

When did you first notice your symptoms? _____

What other forms of treatment have you sought? _____

LIFESTYLE HABITS

What, if any, form of exercise do you do regularly? _____

What does your diet consist of? _____

Please list the frequency you use the following per day or week:

_____ Cigarettes (packs per day) _____ Coffee/Black Tea (cups per day) _____ Daily Water Intake
_____ Alcohol (drinks per week) _____ Soda/Pop _____ Recreational Drugs

List any allergies, food sensitivities or food cravings that you have:

How do you feel about the following areas of your life? Please check the appropriate boxes and indicate any problems you may be experiencing.

	Great	Good	Fair	Poor	Bad	Your Comments
Significant	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Family	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Sex	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Self	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Work	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Exercise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Spirituality	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

MEDICINES AND SUPPLEMENTS

Please list all medications, herbs, vitamins, supplements, over the counter medications you are currently taking (please continue on the back if needed):

Medicine/Supplement	Dosage	Reason	How Long?

MEDICAL

Please list the date of your most recent hospitalizations, emergency room visits for serious medical illness or operations.

MEDICAL HISTORY

Please complete the following table to the best of your knowledge for yourself and blood relatives. Include the date in the appropriate box when possible.

	Self	Mother	Father	Sibling
Allergies				
Asthma				
Pneumonia				
Bronchitis				
Cancer				
Depression/Mental Illness				
Deceased (age)	x			
Kidney Disorder				
Sexually Transmitted Disease (HIV, Herpes, HPV)				
Drug/Alcohol Abuse				
Blood Disorder				
Seizures				
Heart Disease				
High Blood Pressure				
Strokes				
Hepatitis				
Diabetes				
Musculoskeletal Disorder				
Thyroid Disorder				

FOR WOMEN

Age at first menses (menarche) _____ Are you pregnant Yes No # of pregnancies _____
Age of last period (menopause) _____ # of live births _____ # of abortions _____ # of miscarriages _____
Number of days between periods _____ Date of last Gynecologic Exam _____ Pap Smear _____
Number of days of flow _____ Color of flow _____ Date of last Mammogram _____
Clots? Yes No Color _____ Size of clots _____
Average Number of pads/tampons used per day: Day 1 _____ Day 2 _____ Day 3 _____ Day 4 _____ Day 5 _____ + Days _____

Have you been diagnosed with: Fibroids Fibrocystic Breasts Endometriosis Ovarian Cysts PID Other _____
Location of Pain: Lower Abdomen Lower Back Thighs Other _____

Nature of Pain: (Please indicate prior, during or after menses)

Cramping _____ Aching _____
Burning _____ Stabbing _____
Dull _____ Bloating _____
Consistent _____ Intermittent _____
Bearing down sensation _____

Other Symptoms Related to Menses:

Discharge Vaginal Dryness
 Constipation Diarrhea
 Swollen Breasts Mood Swings
 Ravenous Appetite Poor Appetite
 Headaches Nausea
 Hot Flashes Night Sweats
 Increased Libido Decreased Libido
 Insomnia _____ Other problems _____

FOR MEN

Date of Last Prostate Exam _____ PSA Results _____ Manual Exam Prostate Results _____
Frequency of Urination: daytime _____ nighttime _____ Color of urine: clear murky Odor: _____

Symptoms Related to Prostate:

Prostate Problems Delayed Stream Dribbling Incontinence
 Rectal Dysfunction Increased Libido Decreased Libido Impotence
 Premature Ejaculation Retention of Urine Back Pain Groin Pain
 Testicular Pain Other _____

The following lists symptoms that you may or may not ever experience. Please write a "+" if you experience the condition presently or frequently; "C" if you have experienced the condition in the past or leave blank:

FOR EVERYONE

FIRE

___ Insomnia
___ Panic Attacks or Phobias
___ Cold hands/feet
___ Blood clots
___ Dizziness/Fainting
___ Difficulty breathing
___ Mentally Restless
___ Angina Pains
___ Laughing for no reason
___ Chest pain
___ Night sweats
___ Intolerance to weather changes
___ Anxiety

EARTH

___ Excessive appetite
___ Lack of appetite
___ Abdominal pain/cramps
___ Bad breath
___ Diarrhea
___ Indigestion
___ Nausea

___ Belching/Burping
___ Rectal pain
___ Black stools
___ Gas
___ Vomiting
___ Blood in stools
___ Bleeding/bruising easily
___ Cravings
___ Poor Memory
___ Excessive Worry

METAL

___ Hemorrhoids
___ Constipation
___ Decreased sense of smell
___ Pain with deep inhalation
___ Nasal/Sinus Problems
___ Difficulty breathing
___ Cough
___ Feeling of claustrophobia
___ Recent use of antibiotics
___ Colitis or diverticulitis

___ Itching
___ Skin Problems
___ Recurrent sore throats
___ Tendency to easily catch colds
___ Dry skin

WATER

___ Low back pain
___ Sciatica
___ Knee pain
___ Fatigue
___ Kidney stones
___ Decreased sex drive
___ Urinary problems
___ Swelling in hands/feet
___ Changes in texture of hair
___ Hair loss
___ Teeth problems
___ Poor hearing
___ Ringing in the ears
___ Earaches
___ Depression
___ Suicidal Thoughts

WOOD

- Facial pain
- Poor vision
- Color blindness
- Concussions
- Grinding teeth
- Headache/migraines

- Jaw clicking
- Spots in front of eyes
- Eye pain
- Nose bleeds
- Difficulty digesting oily foods
- gallstones
- soft or brittle nails

- Easily angered or agitated
- Spasms or twitching of muscles

Please list any trauma you have experienced or anything else you'd like to share.