Unbroken Flow Acupuncture, LLC

Kendra A. Ward, L.Ac. MAOM
2920 SW Dolph Ct. Ste2, Portland, Oregon 97219
(503) 244-1494

HEALTH HISTORY FORM

Patient Name _____ Birth date _____
Chief Complaint _____

History of present illness:

Where does it hurt? _____
How long have you had this problem? _____
What does it feel like when it hurts? _____
Does the pain/problem occur at a specific time?_____
What other associated problems have you been having? _____
What makes the pain/problem worse or better? _____

Previous Hospitalizations/Surgeries/Serious Illnesses	When?	Hospital, City, State
_____	_____	_____
_____	_____	_____
_____	_____	_____

Medications (include non-prescription, vitamins, supplements, etc.) _____
_____
_____

Family Medical History

	age	diseases	if deceased, cause of death
Father	_____	_____	_____
Mother	_____	_____	_____
Siblings	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
Spouse	_____	_____	_____
Children	_____	_____	_____
	_____	_____	_____

Please mark an "x" next to any conditions you have had and a 'check' after conditions you currently have.

MENTAL/EMOTIONAL
____ Mood swings/depression
____ Eating disorder
____ History of counseling
____ Tension
____ Anxiety or nervousness
____ Considered/attempted suicide

ENDOCRINE
____ Thyroid problems
____ Heat or cold intolerance
____ Fatigue
____ Hypoglycemia
____ Excess thirst or hunger
____ Diabetes
____ Seasonal depression

IMMUNE
____ Chronic fatigue syndrome
____ Chronically swollen glands
____ Chronic infections
____ Frequent colds
____ Autoimmune disease
____ Allergies or hay fever

NEUROLOGIC
____ Seizures
____ Vertigo or dizziness
____ Paralysis
____ Muscle weakness
____ Numbness or tingling
____ Loss of balance
____Loss of memory

SKIN
____ Rashes
____ Color change
____ Eczema
____ Fungus
____ Itching
____ Acne or boils

HEAD
____ Headaches
____ Migraines
____ Head Injury
____ Jaw/TMJ problems

RESPIRATORY
____ Cough
____ Pain on breathing
____ Wheezing or asthma
____ Shortness of breath
____ Bronchitis
____ Spitting up blood

NOSE AND SINUSES
____ Stuffiness
____ Nose Bleeds
____ Hay fever
____ Sinus problems
____ Loss of smell
____ Sinus headaches

EARS
____ Impaired hearing
____ Earaches
____ Ringing

MOUTH AND THROAT
____ Teeth grinding
____ Hoarseness
____ Copious saliva
____ Dry mouth
____ Gum problems
____ Sore tongue or lips
____ Frequent sore throat
____ Mouth sores

EYES
____ Floaters or 'spots'
____ Cataracts
____ Blurriness
____ Double Vision
____ Glaucoma
____ Near/Far sightedness
____ Tearing or dryness
____ Eye pain/strain
____ Impaired vision

MUSCULOSKELETAL
____ Joint pain
____ Joint stiffness
____ Arthritis
____ Weakness
____ Sciatica
____ Broken bones
____ Muscle pain
____ Muscle spasm
____ Osteoporosis

URINARY/KIDNEY
____ Pain on urination
____ Increased frequency
____ Frequency at night
____ Kidney stones
____ Infections
____ Urine leakage

CARDOVASCULAR
____ Heart disease
____ Murmurs
____ Chest pain
____ Poor circulation
____ Blood clots
____ Deep leg pain
____ Valvular problems

____ Palpitations
____ Easy bruising
____ Anemia
____ Varicose veins
____ Fainting
____ Swelling in ankles

REPRODUCTIVE
____ Pain with intercourse
____ Chlamydia
____ Herpes
____ Genital warts
____ Discharge or sores
____ Sexual difficulties
____ Trouble conceiving

GASTROINTESTINAL
____ Trouble swallowing
____ Nausea
____ Vomiting
____ Diarrhea
____ Belching
____ Passing gas
____ Change in appetite

____ Heartburn
____ Ulcer
____ Change in thirst
____ Hemorrhoids
____ Pain or cramps
____ Black stool
____ Blood in toilet

FEMALE ONLY
____ How many days of bleeding per cycle?
____ Are cycles regular?
____ PMS
____ Length of cycle (days)
____ Bleeding between cycles
____ Discharge
____ Painful menses
____ Endometriosis
____ Menopause symptoms
____ Breast lumps or pain
____ Nipple discharge
____ Do you do self breast exams?

____ Age of first menses
____ Clotting
____ Heavy cycles
____ Abnormal paps
____ Ovarian cysts
____ # of pregnancies
____ # of miscarriages
____ # of live births
____ # of abortions

MALE ONLY
____ Hernias
____ Testicular mass
____ Prostate disease
____ Impotence
____ Testicular pain
____ Premature ejaculation

HABITS
Do you exercise? _____ If yes, what kind and how often? _____
Do you have a spiritual practice? _____ If yes, what kind? _____
How many hours do you sleep? _____ Do you sleep well? _____ Use recreational drugs? _____
Drink coffee? _____ Drink cola? _____ Eat 3 meals a day? _____
Use tobacco? _____ Use alcoholic beverages? _____
How much water do you drink daily? _____
Food intolerances (if known) _____

A few final questions:
1. How does your health condition affect your life on an ongoing basis? _____
_____
_____
2. How would your life be different if you didn't have this condition? _____
_____
_____
3. On a scale of 1-10, how committed are you to improving your state of health? _____
4. On a scale of 1-10, how much change are you willing to make at this time for improving your state of health? _____