

Clear Pathways Acupuncture & Wellness  
Initial Visit Health History Form

**\*\*PLEASE USE THE BACK OF THIS FORM IF YOU WANT MORE SPACE.**

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

What health issue/condition do you want treated? Please describe as fully as possible.

How long since onset? \*\*

What makes it better? What makes it worse? Have you received other treatment for this issue? \*\*

Other Current Medical Conditions?	How Long?	Prior or Current Treatment?

Other Healthcare Concerns, in order of importance?	How Long?

Current Medications?	For What?	Prescribed by Whom?

**Do you have any drug allergies?**

Current Herbs/Supplements You Take?	For What?	Prescribed by Whom?

Prior major illnesses/surgeries/hospitalizations?	When? How Long?	Treatment and Remaining Issues, if any?

**FEMALES**

Total Pregnancies \_\_\_\_\_ Living \_\_\_\_\_ Ectopic \_\_\_\_\_ Miscarriages \_\_\_\_\_ Induced Abortions \_\_\_\_\_

When was your last gynecological exam? \_\_\_\_\_ Last Mammogram? \_\_\_\_\_

Is it possible you are currently pregnant? \_\_\_\_\_ Are you trying to become pregnant? \_\_\_\_\_

When was your last menstrual period? \_\_\_\_\_ Is your period regular? \_\_\_\_\_

Have you begun menopause? \_\_\_\_\_ When? \_\_\_\_\_

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Patient Name: \_\_\_\_\_

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

FAMILY HISTORY Complete for each family member, placing an X in the appropriate box:

	Self	Mother	Father	Sister	Brother	Spouse	Child
Allergies							
Blood Disorder							
Diabetes							
Cancers or Tumors							
Seizures							
High Blood Pressure							
Kidney or Bladder disorder							
Stomach or intestinal disorder							
Drug Abuse							
Tuberculosis							
Heart Disease							
Stroke							
Depression/Mental Illness							
Other?							
Age at Death							

Have you ever used?:	Yes/No?	Last Used?	Frequency/Pattern of Use?
Coffee	Y N		
Tobacco	Y N		
Alcohol	Y N		
Marijuana/Hashish	Y N		
Cocaine/Crack	Y N		
LSD/Other hallucinogens	Y N		
Heroin/Other Opiates	Y N		
Methamphetamine/Crank	Y N		
Other?	Y N		
Other?	Y N		

Please describe your current eating patterns (consistency of meals, types of food, etc.) and any problematic patterns or sensitivities you may have:

How would you describe your health, in general? Do you have other health concerns?

Please describe your current exercise frequency/patterns, if any?

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Patient Name: \_\_\_\_\_ date: \_\_\_\_\_

### GENERAL

past	current	
<input type="checkbox"/>	<input type="checkbox"/>	Reduced Appetite
<input type="checkbox"/>	<input type="checkbox"/>	Excessive Appetite
<input type="checkbox"/>	<input type="checkbox"/>	Insomnia
<input type="checkbox"/>	<input type="checkbox"/>	Fatigue
<input type="checkbox"/>	<input type="checkbox"/>	Fevers
<input type="checkbox"/>	<input type="checkbox"/>	Night Sweats
<input type="checkbox"/>	<input type="checkbox"/>	Sweat Easily
<input type="checkbox"/>	<input type="checkbox"/>	Chills
<input type="checkbox"/>	<input type="checkbox"/>	Localized Weakness
<input type="checkbox"/>	<input type="checkbox"/>	Poor Coordination
<input type="checkbox"/>	<input type="checkbox"/>	Change in Appetite
<input type="checkbox"/>	<input type="checkbox"/>	Strong Thirst
<input type="checkbox"/>	<input type="checkbox"/>	Other _____

### CARDIOVASCULAR

past	current	
<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure
<input type="checkbox"/>	<input type="checkbox"/>	Low blood pressure
<input type="checkbox"/>	<input type="checkbox"/>	Blood clots
<input type="checkbox"/>	<input type="checkbox"/>	Palpitations
<input type="checkbox"/>	<input type="checkbox"/>	Fainting
<input type="checkbox"/>	<input type="checkbox"/>	Phlebitis
<input type="checkbox"/>	<input type="checkbox"/>	Chest pain
<input type="checkbox"/>	<input type="checkbox"/>	Irregular heart beat
<input type="checkbox"/>	<input type="checkbox"/>	Cold hands/feet
<input type="checkbox"/>	<input type="checkbox"/>	Swelling of hands/feet
<input type="checkbox"/>	<input type="checkbox"/>	Other _____

### FEMALE

past	current	
<input type="checkbox"/>	<input type="checkbox"/>	Frequent Urinary tract infections
<input type="checkbox"/>	<input type="checkbox"/>	Frequent vaginal infections
<input type="checkbox"/>	<input type="checkbox"/>	Pain/itching of genitalia
<input type="checkbox"/>	<input type="checkbox"/>	Genital lesions / discharge
<input type="checkbox"/>	<input type="checkbox"/>	Pelvic inflammatory disease
<input type="checkbox"/>	<input type="checkbox"/>	Abnormal Pap Smear
<input type="checkbox"/>	<input type="checkbox"/>	Irregular periods
<input type="checkbox"/>	<input type="checkbox"/>	Painful menstrual periods
<input type="checkbox"/>	<input type="checkbox"/>	Premenstrual syndrome
<input type="checkbox"/>	<input type="checkbox"/>	Abnormal bleeding
<input type="checkbox"/>	<input type="checkbox"/>	Menopausal syndrome
<input type="checkbox"/>	<input type="checkbox"/>	Breast lumps
<input type="checkbox"/>	<input type="checkbox"/>	Other _____

### SKIN AND HAIR

past	current	
<input type="checkbox"/>	<input type="checkbox"/>	Rashes
<input type="checkbox"/>	<input type="checkbox"/>	Hives
<input type="checkbox"/>	<input type="checkbox"/>	Itching
<input type="checkbox"/>	<input type="checkbox"/>	Eczema
<input type="checkbox"/>	<input type="checkbox"/>	Pimples
<input type="checkbox"/>	<input type="checkbox"/>	Dryness
<input type="checkbox"/>	<input type="checkbox"/>	Tumors, Lumps

### RESPIRATORY

past	current	
<input type="checkbox"/>	<input type="checkbox"/>	Asthma
<input type="checkbox"/>	<input type="checkbox"/>	Bronchitis
<input type="checkbox"/>	<input type="checkbox"/>	Frequent colds
<input type="checkbox"/>	<input type="checkbox"/>	Chronic obstructive pulmonary disease
<input type="checkbox"/>	<input type="checkbox"/>	Pneumonia
<input type="checkbox"/>	<input type="checkbox"/>	Cough
<input type="checkbox"/>	<input type="checkbox"/>	Coughing blood
<input type="checkbox"/>	<input type="checkbox"/>	Production of phlegm
<input type="checkbox"/>	<input type="checkbox"/>	Other _____

### NEUROLOGICAL

past	current	
<input type="checkbox"/>	<input type="checkbox"/>	Seizures
<input type="checkbox"/>	<input type="checkbox"/>	Tremors
<input type="checkbox"/>	<input type="checkbox"/>	Numbness or tingling of limbs
<input type="checkbox"/>	<input type="checkbox"/>	Concussion
<input type="checkbox"/>	<input type="checkbox"/>	Pain
<input type="checkbox"/>	<input type="checkbox"/>	Paralysis
<input type="checkbox"/>	<input type="checkbox"/>	Other _____

### HEAD AND NECK

past	current	
<input type="checkbox"/>	<input type="checkbox"/>	Dizziness
<input type="checkbox"/>	<input type="checkbox"/>	Fainting
<input type="checkbox"/>	<input type="checkbox"/>	Neck Stiffness
<input type="checkbox"/>	<input type="checkbox"/>	Enlarged lymph glands
<input type="checkbox"/>	<input type="checkbox"/>	Headaches
<input type="checkbox"/>	<input type="checkbox"/>	Concussions
<input type="checkbox"/>	<input type="checkbox"/>	Other _____

### GASTRO-INTESTINAL

past	current	
<input type="checkbox"/>	<input type="checkbox"/>	Nausea
<input type="checkbox"/>	<input type="checkbox"/>	Vomiting
<input type="checkbox"/>	<input type="checkbox"/>	Diarrhea
<input type="checkbox"/>	<input type="checkbox"/>	Belching
<input type="checkbox"/>	<input type="checkbox"/>	Blood in stools/black stools
<input type="checkbox"/>	<input type="checkbox"/>	Bad breadth
<input type="checkbox"/>	<input type="checkbox"/>	Rectal pain
<input type="checkbox"/>	<input type="checkbox"/>	Hemorrhoids
<input type="checkbox"/>	<input type="checkbox"/>	Constipation
<input type="checkbox"/>	<input type="checkbox"/>	Pain or cramps
<input type="checkbox"/>	<input type="checkbox"/>	Indigestion
<input type="checkbox"/>	<input type="checkbox"/>	Gall bladder disorder
<input type="checkbox"/>	<input type="checkbox"/>	Gas
<input type="checkbox"/>	<input type="checkbox"/>	Other _____

### PSYCHOLOGICAL

past	current	
<input type="checkbox"/>	<input type="checkbox"/>	Depression
<input type="checkbox"/>	<input type="checkbox"/>	Anxiety / Stress
<input type="checkbox"/>	<input type="checkbox"/>	Irritability
<input type="checkbox"/>	<input type="checkbox"/>	Treated for emotional / psychological problems
<input type="checkbox"/>	<input type="checkbox"/>	Other _____

### EARS

past	current	
<input type="checkbox"/>	<input type="checkbox"/>	Infection
<input type="checkbox"/>	<input type="checkbox"/>	ringing
<input type="checkbox"/>	<input type="checkbox"/>	Decreased hearing
<input type="checkbox"/>	<input type="checkbox"/>	Other _____

### TESTED FOR?

yes	no		(+) or (-)
<input type="checkbox"/>	<input type="checkbox"/>	HIV	
<input type="checkbox"/>	<input type="checkbox"/>	TB	
<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis	
<input type="checkbox"/>	<input type="checkbox"/>	Gonorrhea	
<input type="checkbox"/>	<input type="checkbox"/>	Chlamydia	
<input type="checkbox"/>	<input type="checkbox"/>	Syphilis	

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**EYES**

past	current	
ف	ف	Blurred vision
ف	ف	Visual changes
ف	ف	Poor night vision
ف	ف	Spots
ف	ف	Cataracts
ف	ف	Glasses/Contacts
ف	ف	Eye inflammation
ف	ف	Other_____

**URINARY**

past	current	
ف	ف	Kidney stones
ف	ف	Pain on urination
ف	ف	Frequent urination
ف	ف	Blood in urine
ف	ف	Urgency to urinate
ف	ف	Unable to hold urine
ف	ف	Other_____

ف ف  
ف ف

Genital warts  
Herpes: oral / genital

**NOSE, THROAT, AND MOUTH**

past	current	
ف	ف	Nose bleeds
ف	ف	Sinus infection
ف	ف	Hay fever or allergies
ف	ف	Recurring sore throats
ف	ف	Grinding teeth
ف	ف	Difficulty swallowing

**MALE**

past	current	
ف	ف	Pain /itching of genitalia
ف	ف	Genital lesions / discharge
ف	ف	Impotence
ف	ف	Weak urinary stream
ف	ف	Lumps in testicles
ف	ف	Other _____

When was your most recent physical exam by an MD?

What is your height?

Weight?

Blood Pressure? /

Last Blood Pressure Examination?