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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GENERAL

past	current	
☐	☐	Reduced Appetite
☐	☐	Excessive Appetite
☐	☐	Insomnia
☐	☐	Fatigue
☐	☐	Fevers
☐	☐	Night Sweats
☐	☐	Sweat Easily
☐	☐	Chills
☐	☐	Localized Weakness
☐	☐	Poor Coordination
☐	☐	Change in Appetite
☐	☐	Strong Thirst
☐	☐	Other_____

SKIN AND HAIR

past	current	
☐	☐	Rashes
☐	☐	Hives
☐	☐	Itching
☐	☐	Eczema
☐	☐	Pimples
☐	☐	Dryness
☐	☐	Tumors, Lumps

HEAD AND NECK

past	current	
☐	☐	Dizziness
☐	☐	Fainting
☐	☐	Neck Stiffness
☐	☐	Enlarged lymph glands
☐	☐	Headaches
☐	☐	Concussions
☐	☐	Other _____

EARS

past	current	
☐	☐	Infection
☐	☐	Ringing
☐	☐	Decreased hearing
☐	☐	Other_____

CARDIOVASCULAR

past	current	
☐	☐	High blood pressure
☐	☐	Low blood pressure
☐	☐	Blood clots
☐	☐	Palpitations
☐	☐	Fainting
☐	☐	Phlebitis
☐	☐	Chest pain
☐	☐	Irregular heart beat
☐	☐	Cold hands/feet
☐	☐	Swelling of hands/feet
☐	☐	Other_____

RESPIRATORY

past	current	
☐	☐	Asthma
☐	☐	Bronchitis
☐	☐	Frequent colds
☐	☐	Chronic obstructive pulmonary disease
☐	☐	Pneumonia
☐	☐	Cough
☐	☐	Coughing blood
☐	☐	Production of phlegm
☐	☐	Other_____

GASTRO-INTESTINAL

past	current	
☐	☐	Nausea
☐	☐	Vomiting
☐	☐	Diarrhea
☐	☐	Belching
☐	☐	Blood in stools/black stools
☐	☐	Bad breadth
☐	☐	Rectal pain
☐	☐	Hemorrhoids
☐	☐	Constipation
☐	☐	Pain or cramps
☐	☐	Indigestion
☐	☐	Gall bladder disorder
☐	☐	Gas
☐	☐	Other_____

FEMALE

past	current	
☐	☐	Frequent Urinary tract infections
☐	☐	Frequent vaginal infections
☐	☐	Pain/itching of genitalia
☐	☐	Genital lesions / discharge
☐	☐	Pelvic inflammatory disease
☐	☐	Abnormal Pap Smear
☐	☐	Irregular periods
☐	☐	Painful menstrual periods
☐	☐	Premenstrual syndrome
☐	☐	Abnormal bleeding
☐	☐	Menopausal syndrome
☐	☐	Breast lumps
☐	☐	Other_____

NEUROLOGICAL

past	current	
☐	☐	Seizures
☐	☐	Tremors
☐	☐	Numbness or tingling of limbs
☐	☐	Concussion
☐	☐	Pain
☐	☐	Paralysis
☐	☐	Other_____

PSYCHOLOGICAL

past	current	
☐	☐	Depression
☐	☐	Anxiety / Stress
☐	☐	Irritability
☐	☐	Treated for emotional / psychological problems
☐	☐	Other_____

TESTED FOR?

yes	no		(+) or (-)
☐	☐	HIV	
☐	☐	TB	
☐	☐	Hepatitis	
☐	☐	Gonorrhea	
☐	☐	Chlamydia	
☐	☐	Syphillis	

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EYES

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

NOSE, THROAT, AND MOUTH

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

URINARY

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

MALE

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

☐	☐	Genital warts
☐	☐	Herpes: oral / genital

When was your most recent physical exam by an MD?
What is your height? Weight?
Blood Pressure? / Last Blood Pressure Examination?