Patient History

Thrive Acupuncture of Utah

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

Age: \_\_\_ Birthdate: \_\_\_\_\_\_ Sex: Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ Years: \_\_\_\_\_\_\_\_\_\_\_

Who referred you to this office? \_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Main Reason for This Visit:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Known Diagnoses or Health Problems: Personal Health Goals:

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

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

Previous/Present Doctor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Past Medical History** (Please list or describe):

 Year/Date Year/Date

Operations or surgery: Head Injury: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Hospitalizations: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

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

Accidents: Serious Illnesses: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

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

Broken Bones: Other:\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

## Medications, Allergies, and Sensitivities

Please list any medications or drugs, and any foods or other substances to which you are allergic:

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

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

List all medications you are taking (including over the List any vitamin, herb, or

counter meds and birth control pills – past or current): supplements you are taking:

Name: Frequency: daily Name: Frequency:

## Health Habits Check yes or no and circle day or week:

Tobacco smoking  Yes  No packs per day/week type of tobacco

Coffee  Yes  No cups per day/week  Reg  Decaf

Tea  Yes  No cups per day/week  Reg  Herbal

Alcohol  Yes  No per day/week  Wine  Beer  Liquor

Soft drinks  Yes  No drinks per day/week  Regular  Diet

Artificial Sweeteners  Yes  No packs per day/week

Glasses water/fluid per day plain water juice other

What exercises/activities do you do and how often?

How many hours of sleep do you get per night? Is it restful? \_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have an adequate energy level? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mark the stress level in your life (0 is the least, 10 is the most):

How much does stress affect you (0 is the least, 10 is the most)?

What are the major stresses in your life presently?

How many hours per week do you work? How many hours per week do you have for free time?\_\_\_\_\_\_\_\_\_\_\_

Favorite pastime/recreational activity:

Have you ever had any of the following? Please indicate “**C”** for current and “**P”** for past:

## GENERAL

\_\_\_Fever, chills, sweats \_\_\_ Snoring \_\_\_ Burning or painful urination

\_\_\_ Night sweats \_\_\_ Sore throats \_\_\_ Blood in urine

\_\_\_ Fatigue \_\_\_ Hoarseness \_\_\_ Straining to urinate

\_\_\_ Nervousness/anxiety \_\_\_ Tooth & gum problems \_\_\_ Hernia

\_\_\_ Irritability \_\_\_ Loss of taste \_\_\_ Sexually transmitted disease

\_\_\_ Depression \_\_\_ Sores in mouth \_\_\_ Kidney stones

\_\_\_ Generally feel “run down” \_\_\_ Sore tongue \_\_\_ Kidney infections

\_\_\_ Sexual abuse (optional) **RESPIRATORY FEMALE**

\_\_\_ Emotional abuse (optional) \_\_\_ Frequent “colds” \_\_\_ Last menstrual period\_9/4\_date

\_\_\_ Loss of weight \_\_\_ Difficulty breathing \_\_\_ Currently pregnant

**SKIN** \_\_\_ Chronic or frequent cough \_\_\_ Age periods started

\_\_\_ Non-healing sore \_\_\_ Asthma or wheezing \_\_\_ Duration of flow \_\_\_ days

\_\_\_ Hives, rash \_\_\_ Emphysema \_\_\_ Days in cycle \_\_\_\_\_\_\_ days

\_\_\_ Eczema, psoriasis \_\_\_ Spitting up blood \_\_\_ Pelvic pain or infection

\_\_\_ Frequent infection or boils \_\_\_ Pleurisy (pain with breathing) \_\_\_ Excess discharge

\_\_\_ Abnormal pigmentations, moles \_\_\_ Pneumonia \_\_\_ Excess discharge

\_\_\_ Warts \_\_\_ Coughing up sputum \_\_\_ PMS

\_\_\_ Herpes: **CARDIOVASCULAR** \_\_\_ Menstrual cramping

 \_\_\_ lips \_\_\_ High blood pressure \_\_\_ Irregular cycle

 \_\_\_ genital \_\_\_ Palpitation, irregular heart beat \_\_\_ Number of pregnancies

 \_\_\_ zoster (shingles) \_\_\_ Rheumatic fever \_\_\_ Number of children

\_\_\_ Skin cancer or melanoma \_\_\_ Chest pain or angina \_\_\_ Number of ectopic pregnancies

\_\_\_ Brittle or weak nails \_\_\_ Shortness of breath with walking\_\_\_ Number of miscarriages

\_\_\_ Infected nails \_\_\_ Shortness of breath lying down \_\_\_ Number of abortions

**ENDOCRINE** \_\_\_ Difficulty walking two blocks \_\_\_ DES exposure

\_\_\_ Diabetes \_\_\_ Heart trouble \_\_\_ Uterine fibroids

\_\_\_ Thyroid disease \_\_\_ Heart attack \_\_\_ Hysterectomy

\_\_\_ Heat or cold intolerance \_\_\_ Heart murmur \_\_\_ Date of menopause \_\_\_\_\_\_

\_\_\_ Dry skin \_\_\_ Awakening in the night smothering\_\_ Hot flashes

\_\_\_ Change in hair growth or texture \_\_\_ Swelling of hands, feet, or ankles\_\_\_ Menopausal bleeding

\_\_\_ Excessive thirst or urination \_\_\_ Need more than one pillow to sleep\_\_ Breast pain

\_\_\_ Sexual problems \_\_\_ Pain in calves with walking relieved by rest\_\_ Breast lumps

\_\_\_ Hormone therapy \_\_\_ Varicose veins \_\_\_ Nipple discharge or bleeding

\_\_\_ Low or high sex drive **HEMATOLOGIC**  \_\_\_ Abnormal PAP smear

\_\_\_ Radiation to neck or face area \_\_\_ Excessive bleeding/bruising **MALE**

\_\_\_ Low blood sugar \_\_\_ Anemia \_\_\_ Testicular pain/swelling

**HEAD-EYES-EARS-NOSE-THROAT**  \_\_\_ Phlebitis/blood clots in veins \_\_\_ Urinary frequency or burning

\_\_\_ Headache \_\_\_ Are you slow to heal after \_\_\_ Difficulty in starting stream of urine

 \_\_\_ sinus (allergy) cuts or bruising? \_\_\_ Discharge from penis

 \_\_\_ tension \_\_\_ Difficulty with bleeding excessively \_\_\_ Frequent night urination

 \_\_\_ migraine after tooth extraction or surgery\_\_\_ Prostate pain/swelling

\_\_\_ Head feels “heavy” \_\_\_ Mononucleosis \_\_\_ Undescended testicle

\_\_\_ Loss of memory **GASTROINTESTINAL**  \_\_\_ Impotence

\_\_\_ Light-headedness or “spaciness” \_\_\_ Painful bowel movement **LOCOMOTOR-MUSCULOSKELETAL**

\_\_\_ Light bothers eyes \_\_\_ Vomiting blood or food\_\_\_ Joint swelling

\_\_\_ Eye disease or injury \_\_\_ Heartburn/indigestion \_\_\_ Arthritis or joint pain

\_\_\_ Blurry vision \_\_\_ Food sticks in throat \_\_\_ Weakness of muscles or joints

\_\_\_ Double vision \_\_\_ Difficulty swallowing \_\_\_ Back pain (see next page)

\_\_\_ Loss of vision \_\_\_ Diarrhea or loose stools \_\_\_ Difficulty walking

\_\_\_ Glaucoma, cataracts \_\_\_ Ulcer (stomach or duodenal) \_\_\_ Leg cramps

\_\_\_ Loss of balance \_\_\_ Gallbladder disease or stones \_\_\_ Leg ulcers

\_\_\_ Dizziness or vertigo \_\_\_ Liver trouble/hepatitis **MENTAL EMOTIONAL/NEUROLOGIC**

\_\_\_ Loss of hearing \_\_\_ Bloody or black stools \_\_\_ Fainting spells

\_\_\_ Ear disease \_\_\_ Constipation \_\_\_ Epilepsy/Seizures

\_\_\_ Impaired hearing \_\_\_ “Nervous” stomach \_\_\_ Stroke or mini-stroke

\_\_\_ Ringing/buzzing in ears \_\_\_ Nausea and/or vomiting \_\_\_ Paralysis

\_\_\_ Ear pain \_\_\_ Bloating in stomach after eating \_\_\_ Weakness of an arm or leg

\_\_\_ Discharge from ear \_\_\_ Bloating or gas in lower abdomen \_\_\_ Insomnia or trouble sleeping

\_\_\_ Runny nose or nasal discharge \_\_\_ Thin or ribbon like stools Tendency towards:

\_\_\_ Nosebleeds \_\_\_ Hard or difficult bowel movements \_\_\_ Sadness/grief/depression

\_\_\_ Chronic sinus trouble **GENITOURINARY** \_\_\_ Anger/irritability

 \_\_\_ Frequent urination\_\_\_ Anxiety/fear

 \_\_\_ Involuntary loss of urine \_\_\_ Mental overactivity

# **NECK LOW BACK HIPS, LEGS, AND FEET**

\_\_\_ Pain \_\_\_ Low back pain \_\_\_ Pain in buttocks (R/L)

\_\_\_ Neck pain with movement \_\_\_ upper lumbar \_\_\_ pain in hip joint (R/L)

 \_\_\_ forward \_\_\_ lower lumbar \_\_\_ pain down leg (R/L)

 \_\_\_ backward \_\_\_ Sacroiliac pain \_\_\_ Pain down both legs

 \_\_\_ turning to the left \_\_\_ Low back pain is worse when \_\_\_ Knee pain (R/L)

 \_\_\_ turning to the right \_\_\_ working \_\_\_ Leg cramps (R/L)

\_\_\_ bending to the left \_\_\_ lifting \_\_\_ Cramps in feet (R/L)

 \_\_\_ bending to the right \_\_\_ stooping \_\_\_ Pins & needles in legs (R/L)

\_\_\_ Pinched nerve in neck \_\_\_ standing \_\_\_ Numbness of leg (R/L)

\_\_\_ Neck feels out of place \_\_\_ sitting \_\_\_ Numbness of feet (R/L)

\_\_\_ Muscle spasms in neck \_\_\_ bending \_\_\_ Numbness of toes (R/L)

\_\_\_ Grinding sounds in neck \_\_\_ coughing \_\_\_ Feet feel cold (R/L)

\_\_\_ Popping sounds in neck \_\_\_ lying down (sleeping) \_\_\_ Swollen ankles (R/L)

\_\_\_ Arthritis in neck \_\_\_ walking \_\_\_ Swollen feet (R/L)

\_\_\_ Swollen glands \_\_\_ other

 \_\_\_ Pain relieved with **THERAPEUTIC TECHNIQUES**

**SHOULDERS** \_\_\_ ice \_\_\_ Acupuncture

\_\_\_ Pain in shoulder joint (R/L) \_\_\_ heat \_\_\_ Herbal Medicine

\_\_\_Pain across shoulders \_\_\_movement \_\_\_ Homeopathy/Bach Flower

\_\_\_ Bursitis (R/L) \_\_\_ physical therapy \_\_\_ Nutrition

\_\_\_ Arthritis (R/L) \_\_\_ topical analgesics \_\_\_ Rolfing/Structural

\_\_\_ Can’t raise arm \_\_\_ medications integration

 \_\_\_ above shoulder level \_\_\_ other \_\_\_ Massage

 \_\_\_ over head \_\_\_ Slipped disk \_\_\_ Chiropractic

\_\_\_ Can’t put arm behind back \_\_\_ Low back feels out of place \_\_\_ Psychotherapy (Optional)

 (as if putting on a bra) \_\_\_ Muscle Spasms \_\_\_ Visualization/Guided

\_\_\_ Tension in shoulders imagery

\_\_\_ Pinched nerve in shoulder (R/L) \_\_\_ Biofeedback

\_\_\_ Muscle spasms in shoulders \_\_\_ Movement Therapy

 \_\_\_ Physical Therapy

**ARMS AND HANDS** \_\_\_ Reiki

\_\_\_ Pain in upper arm (R/L) \_\_\_ Craniosacral Therapy

\_\_\_ Pain in elbow (R/L) \_\_\_ Therapeutic Exercise

\_\_\_ Movement aggravates pain \_\_\_ Other \_\_\_\_\_\_\_\_\_\_\_

\_\_\_ Pain in forearm (R/L)

\_\_\_ Pain in hands (R/L)

\_\_\_ Pain in fingers (R/L)

\_\_\_ Feeling of pins & needles in arms (R/L)

\_\_\_ Feeling of pins & needles in fingers (R/L)

\_\_\_ Numbness in arms (R/L)

\_\_\_ Numbness in fingers (R/L)

\_\_\_ Fingers go to sleep (R/L)

\_\_\_ Hands cold (R/L)

\_\_\_ Swollen joints in fingers (R/L)

\_\_\_ Arthritis in fingers (R/L)

\_\_\_ Loss of grip strength (R/L)

# **MID-BACK & CHEST**

\_\_\_ Mid-back pain

\_\_\_ Pain between shoulder blades

\_\_\_ Sharp stabbing pain

\_\_\_ Dull ache

\_\_\_ Pain from front to back

\_\_\_ Muscle spasms in mid back

\_\_\_ Pain in kidney area

\_\_\_ Chest pain

\_\_\_ Shortness of breath

\_\_\_ Pain around ribs