NEW PATIENT HEALTH HISTORY INITIALS:_______

NAME		
First:	Middle:	Last:
Preferred Name:		Date of Birth:

ADDRESS & PHONE		
Street:		
City:	State:	Zip:
Home:	Work:	Cell:
Email:		
May we contact you at the above numbers? Yes ☐ No☐	May we leave a message? Yes☐ No☐	
Emergency Contact Name:	Tel.	

How did you find out about us?	
Have you ever had acupuncture before? Yes ☐ No☐	Naturopathic Medicine before? Yes ☐ No☐

PRIMARY MEDICAL CARE	
Please provide the name of your physician:	
Approximate date of last physical?	Last PAP?

SOCIAL
Who do you live with?
What do you do for work?
What are your hobbies?
Do you smoke? Yes ☐ No☐ If so, how much and for how long?
Recreational drug use? If so, which ones, how much and for how long?

VITALS		
Height:	Current Weight:	Desired Weight:
Usual Weight:	Highest Weight:	Lowest Weight:
Heart rate:	Last known blood pressure:	

ALLERGIES	
Please list any allergies to food, medicine, or environmental factors.	What happens if you are exposed to this allergen?

NEW PATIENT HEALTH HISTORY

INITIALS:_______

SENSITIVITIES	
Please list any substances or foods you feel that you are sensitive to:	What happens if you are exposed to this sensitivity?

MEDICATIONS	
What medications are you currently taking? Include oral contraceptives and other daily meds. Please list dosages, if known.	What are you taking this for?
1)	
2)	
3)	
4)	
5)	

SUPPLEMENTS	
What vitamins or supplements are you currently taking? Amounts?	What are you taking this for?
1)	
2)	
3)	
4)	
5)	

HEALTH CONCERNS				
Please list your top 3 health concerns:	How long has this been going on?	Mild	Moder ate	Severe
1)				
2)				
3)				

NEW PATIENT HEALTH HISTORY INITIALS:_______

BETTER / WORSE	
For the above health concerns, what makes it feel better?	What makes it feel worse?
1)	
2)	
3)	

PRIOR TREATMENTS	
What other treatments have you tried for the above concerns?	Did it help?
1)	Yes ☐ No ☐ Somewhat ☐
2)	Yes ☐ No ☐ Somewhat ☐
3)	Yes ☐ No ☐ Somewhat ☐
4)	Yes ☐ No ☐ Somewhat ☐
5)	Yes ☐ No ☐ Somewhat ☐

HEALING EXPECTATIONS	
For the above health concerns, How does this affect your quality of life?	How long do you think it will take for each of them to resolve?
1)	
2)	
3)	

WILLINGNESS AND ABILITY					
For the above health concerns, how willing or able are you to modify the following areas of your life to improve your health	Please Rate your willingness from 1 (not willing) to 5 (very willing)				
1) Significantly modify your diet	1	2	3	4	5
2) Take several supplements each day or multiple times / day	1	2	3	4	5
3) Keep a record of everything you eat and drink each day	1	2	3	4	5

4) Modify your lifestyle habits (change your sleep, work habits etc)	1	2	3	4	5
5) Practice a daily relaxation technique	1	2	3	4	5
6) Engage in regular exercise	1	2	3	4	5
7) Have periodic lab tests to assess your progress	1	2	3	4	5

OBSTACLES TO CURE					
How confident are you of your ability to follow through on the above health related activities?	1	2	3	4	5
What do you anticipate may be the obstacles to follow through on each of the above?	Can this be solved?				
1)					
2)					
3)					
4)					
5)					
6)					
7)					

SURGERIES		
Please list any surgical procedures you have had.	When?	Why?
☐ Appendectomy		
☐ Hysterectomy +/- Ovaries		
☐ Gallbladder		
☐ Hernia Repair		
☐ Tonsillectomy		
☐ Dental Surgery		
☐ Joint Replacement (Hip, Knee)		
☐ Heart Surgery		
☐ Angioplasty / Stent		
☐ Bypass Valve		
☐ Pacemaker		
☐ Other:		

NEW PATIENT HEALTH HISTORY INITIALS:______

EXERCISE
How often do you exercise?
Do you feel better or worse after exercise?
What prevents you from exercising?

STRESS ASSESSMENT		
Please list your top 3 stressors:	Rate the stress 1-10	How long has this been going on?
1)		
2)		
3)		

STRESS RELIEF
How do you de-stress? What do you really turn to when you are stressed?
1)
2)
3)
4)

Shade the column to the degree of satisfaction you have in the following areas of your life:

LIFE SATISFACTION:									
% satisfied									
100									
90									
80									
70									
60									
50									
40									
30									
20									
10									
0									
	Family	Friends	Finance	Fun	Health	Personal growth	Exercise	Home	Romance

NEW PATIENT HEALTH HISTORY INITIALS:______

WHAT BRINGS YOU JOY?
Please list your top 3 joyful activities
1)
2)
3)

TRAUMATIC OR EMOTIONALLY IMPACTFUL EVENTS	
Please list any emotionally traumatic or emotionally significant events that you care to share:	When did this happen?

FEARS & PHOBIAS	
What are your fears?	What helps?

ENVIRONMENTAL	
Do you take your shoes off when you enter your house?	Yes ☐ No ☐
Is there any visible mold or is there the smell of mold?	Yes ☐ No ☐
Have you tested your home for Radon?	Yes ☐ No ☐
Gas stove or electric?	
Use humidifiers or dehumidifiers?	
Laundry detergent brand:	
Shampoo brand:	
Do you use Teflon coated cookware?	Yes ☐ No ☐
Do you use plastic containers?	Yes ☐ No ☐
Do you use perfumes/ air fresheners?	Yes ☐ No ☐
Do you use fabric softener?	Yes ☐ No ☐
% of your food that you buy organic?	
Do you have carpet in your home?	Yes ☐ No ☐
When was the last time you purchased new furniture?	
Do you use a water filter? What brand?	Yes ☐ No ☐
Do you use a shower filter? What brand?	Yes ☐ No ☐

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NEW PATIENT HEALTH HISTORY INITIALS:______

Do you have mercury fillings?	Yes ☐ No ☐
Are you exposed to known toxic substances in your home or workplace?	Yes ☐ No ☐
How often do you dry clean your clothes?	
Do you place your laptop on your body when using it?	Yes ☐ No ☐

Have you ever had an exposure to any hazardous chemicals that you are aware of?
☐ Lead ☐ Mercury ☐ Arsenic ☐ Other Heavy Metals ☐ Asbestos ☐ Radioactive materials ☐ Radon ☐ Trihalomethanes ☐ Tobacco Smoke ☐ Pesticides
☐ Dioxins ☐ Volatile Organic Compounds (VOCs) ☐ Polychlorinated biphenyls (PCBs)
☐ Other/ Please specify ____

OBSTETRICAL HISTORY

OBSTETRICAL HISTORY	
Are you currently trying to get pregnant?	
How long have you been trying?	
What methods have you tried?	
Do you have a known obstacle to pregnancy?	
Is there a chance that you might be pregnant now? Yes ☐ No ☐	
Have you been pregnant before? Yes ☐ No ☐ If so, at what age / ages?	
# of live births:	# of living children:
Vaginal (V) or ceserian (C)? 1) 2) 3) 4)	
How many hours did you labor for each child? 1) 2) 3) 4)	
At what weeks gestation did you deliver for each child? 1) 2) 3) 4)	
Any complications during pregnancy or labor?	
# of abortions:	# of miscarriages: at what month of pregnancy?
Did you breastfeed? Yes ☐ No ☐ How long? 1) 2) 3) 4)	

GYNECOLOGICAL HISTORY

GYNECOLOGICAL HISTORY	
Name of OB/Gyn:	
Date of last Pap:	Result?
Age at First Period: Date of last period: # of days bleeding:	
Irregular Periods: Yes □ No □	Bleeding between periods: Yes □ No □
Length of cycle:	Clots? Yes □ No □ Size: rice, pea, dime, nickel, quarter, larger
Color of blood: bright red, dark red, purplish, dark brown, light brown, black	
PMS symptoms:	
How many days before period?	Ends day of cycle.

NEW PATIENT HEALTH HISTORY INITIALS:______

Contraception used:	
Menopause: Yes □ No □	Symptoms:
Date of last mammogram / thermogram:	

SLEEP & ENERGY LEVELS
How many hours of sleep do you get ?
Difficulty falling asleep? Yes ☐ No ☐
What time do you go to sleep?
What time do you wake up for the day?
Do you wake during the night? Yes ☐ No ☐
What wakes you?
Is there a time that you usually wake up in the night?
Do you have recurring themes in your dreams?
Do you have nightmares? Yes ☐ No ☐ How often?
Do you feel refreshed in the morning? Yes ☐ No ☐
Rate your energy levels when you first wake from 1-10 /10
What times in the day do you feel most tired:
What times in the day do you feel most energetic:

STIMULANTS AND SEDATIVES		
How often do you use the following:	How often	Why?
Coffee or caffeinated beverages	☐Daily ☐Weekly ☐Monthly ☐Less	
Alcoholic beverages	☐Daily ☐Weekly ☐Monthly ☐Less	
Sugar	☐Daily ☐Weekly ☐Monthly ☐Less	
Dairy	☐Daily ☐Weekly ☐Monthly ☐Less	
Wheat	☐Daily ☐Weekly ☐Monthly ☐Less	
Other:		

CURRENT DIET
Do you currently follow a special diet or nutritional program? Yes □ No □ *Check all that apply*
☐Low Fat ☐Low Carbohydrate ☐High Protein ☐Low Sodium ☐Diabetic ☐No Dairy ☐No Wheat ☐Gluten Restricted ☐Vegetarian ☐Vegan ☐Detox Diet ☐Low Glycemic ☐ Yeast

NEW PATIENT HEALTH HISTORY INITIALS:_______

Restricted/ Candida ☐Anti-inflammatory ☐SCD ☐GAPS ☐Low FODMAP ☐Low Histamine ☐ Weston Price / Sally Fallon ☐SIBO ☐Food Combining ☐No Nightshades ☐Feingold
☐ Other ______________________________

24 hour FOOD RECALL & CRAVINGS
What foods or flavors do you crave (sweet, salty, sour, pungent, carbs, vinegar, spicy)? What are your comfort foods?
1)
2)
3)
Please list everything you ate and drank yesterday:
Breakfast:
Snacks:
Lunch:
Snacks:
Dinner:

FOOD HABITS
Do you grocery shop? Yes ☐ No ☐ If no, who does the shopping? ______________________
Where do you mainly buy your food?______________________
Do you cook? Yes ☐ No ☐ Do you enjoy cooking regularly? ______/10
If not, who does the cooking? ______________________________
How many meals do you eat out per week? 0-1 ☐ 1-3 ☐ 3-5 ☐ >5 meals per week ☐

CHILDHOOD ILNESSES AND VACCINES
Please list any illnesses or vaccines you had as a child:
☐ Measles ☐ Mumps ☐ Rubella ☐ Diptheria ☐ Pertussis (Whooping Cough) ☐ Tetanus ☐ Chicken Pox ☐ HIB ☐ Scarlet Fever ☐ Polio

PERSISTENT VIRUSES & PARASITES
☐ Epstein Barr ☐ Hepatitis B ☐ Hepatitis C ☐ HIV ☐ HPV ☐ Cytomegalovirus ☐ Herpes Virus ☐ Human T-Cell Leukemia Virus ☐ Varicella Zoster ☐Parasites: ______________________

INFECTIOUS
Do you have any infectious conditions? Please list them.
1)
2)

3)

FAMILY HISTORY												
Do your family members have any of the following?												
	Mother	Father	Brother(s)	Sistier (s)	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather	Aunts	Uncles	Cousins	Other
Age if still alive												
Age at death												
Cancer												
Colon Cancer												
Breast or Ovarian Cancer												
Heart Disease												
Hypertension												
Obesity												
Diabetes												
Stroke												
Inflammatory Arthritis (Rheumatoid, Psoriatic, Ankylosing Spondylitis)												
Inflammatory Bowel Dz												
Multiple Sclerosis												
Autoimmune Diseases (Lupus, etc)												
Irritable Bowel Syndrome												
Celiac Disease												
Asthma												
Eczema												
Psoriasis												
Dementia												
Parkinson’s												
Alzheimer’s												
ALS or other motor neuron diseases												
Genetic Disorders												
Substance Abuse (eg alcoholism)												

NEW PATIENT HEALTH HISTORY INITIALS:______

	Mother	Father	Brother(s)	Sistier (s)	Maternal Grandmot	Maternal Grandfath	Paternal Grandmot	Paternal Grandfath	Aunts	Uncles	Cousins	Other
Psychiatric Disorders												
ADHD												
Depression												
Bipolar Disorder												
Schizophrenias												
Autism Spectrum												
Porphyrias												
Thalassemias												
Hemochromatosis												
Bleeding Disorders												

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1. Please mark the **grey box** if you have experienced the symptom **regularly in your past**.
2. Please mark the **white box** if you experience the symptom **regularly, within the last 6 months**.
3. You may also **rate the severity** for each symptom, from **1 (mild), 2 (moderate)** to **3 (severe).**

TEMPERATURE

past	6mo	
☐	☐	Cold Hands & Feet
☐	☐	Cold Fingers & Toes
☐	☐	Low Body Temp
☐	☐	Easily Feel Cold
☐	☐	Easily Feel Hot
☐	☐	Low Grade Fever
☐	☐	Night sweats
☐	☐	Facial Flushing
☐	☐	Hot Flashes
☐	☐	Hot at night

EARS

- ☐ ☐ Ear Pain
- ☐ ☐ Ear Fullness
- ☐ ☐ Ear Itching
- ☐ ☐ Tinnitus – High pitch
- ☐ ☐ Tinnitus – Low pitch
- ☐ ☐ Hearing Loss
- ☐ ☐ Ear Infections
- ☐ ☐ Ears get red easily

EYES

- ☐ ☐ Eye Hemorrhages
- ☐ ☐ Eye Crusting
- ☐ ☐ Eye Pain
- ☐ ☐ Conjunctivitis
- ☐ ☐ Near-Sighted
- ☐ ☐ Far-Sighted
- ☐ ☐ Poor Night Vision
- ☐ ☐ Macular Degeneration
- ☐ ☐ Retinal Detachment
- ☐ ☐ Vitreous Detachment
- ☐ ☐ Eye Itching
- ☐ ☐ Eye Watering
- ☐ ☐ Eye Dryness
- ☐ ☐ Eye Redness
- ☐ ☐ Eye Discharges

HEAD

- ☐ ☐ Migraine
- ☐ ☐ Head Injury
- ☐ ☐ Frontal Headaches
- ☐ ☐ Temporal Headaches
- ☐ ☐ Occipital Headaches
- ☐ ☐ Vertex Headaches
- ☐ ☐ One-Sided Headache
- ☐ ☐ Tension Headache
- ☐ ☐ Cluster Headache
- ☐ ☐ Headache over eyes
- ☐ ☐ Sinus Headaches
- ☐ ☐ Sensitive to Noise
- ☐ ☐ Hair Loss
- ☐ ☐ Dandruff

NOSE

- ☐ ☐ Distorted Sense of Smell
- ☐ ☐ Polyps
- ☐ ☐ Deviated Septum
- ☐ ☐ Nosebleeds
- ☐ ☐ Swollen Adenoids
- ☐ ☐ Difficulty breathing through nose
- ☐ ☐ Snoring
- ☐ ☐ Cold Nose
- ☐ ☐ Dryness
- ☐ ☐ Post Nasal Drip
- ☐ ☐ Stuffy Nose

MOUTH / THROAT

- ☐ ☐ Jaw Pain
- ☐ ☐ TMJ
- ☐ ☐ Diminished Taste
- ☐ ☐ Bitter taste
- ☐ ☐ Metallic Taste
- ☐ ☐ Sweet taste
- ☐ ☐ Canker Sores on tongue
- ☐ ☐ Cold Sores (Herpes)
- ☐ ☐ Cracking at Corner of Lips
- ☐ ☐ Dentures
- ☐ ☐ Cavities
- ☐ ☐ Mercury Fillings
- ☐ ☐ Tongue Swelling
- ☐ ☐ Tongue Pain
- ☐ ☐ Tonsillitis
- ☐ ☐ Strep Infection
- ☐ ☐ Dry Lips
- ☐ ☐ Red Lips
- ☐ ☐ Pale Lips
- ☐ ☐ Dry mouth
- ☐ ☐ Strong Breath
- ☐ ☐ Toothache
- ☐ ☐ Mouth breathing
- ☐ ☐ Bleeding gums
- ☐ ☐ Hoarseness
- ☐ ☐ Loss of Voice

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RESPIRATORY

past	6mo	
☐	☐	Cough-Dry
☐	☐	Cough-Productive
☐	☐	Wheezing
☐	☐	Asthma
☐	☐	Chest tightness
☐	☐	Chest Pain
☐	☐	Difficulty taking a full breath
☐	☐	Difficult exhale
☐	☐	Difficult inhale
☐	☐	Weak / quiet voice
☐	☐	Mucus - thin
☐	☐	Mucus – thick
☐	☐	Mucus – scanty
☐	☐	Mucus – yellow
☐	☐	Mucus – clear
☐	☐	Mucus – white
☐	☐	Mucus – green
☐	☐	Mucus – brown
☐	☐	Mucus – blood-tinged
☐	☐	Burning sensation
☐	☐	Shallow breathing

DIGESTIVE

☐	☐	Anal Spasms
☐	☐	Anal Fissures
☐	☐	Anal Itching

Bloating of:

☐	☐	Lower Abdomen
☐	☐	Whole Abdomen
☐	☐	Bloating After Meals
☐	☐	Blood in Stools
☐	☐	Constipation
☐	☐	Diarrhea
☐	☐	Soft Stool
☐	☐	Hard stool
☐	☐	Slow bowel movement
☐	☐	Alternating Diarrhea & Constipation
☐	☐	Difficulty swallowing
☐	☐	Excess Gas/ Flatulence
☐	☐	Hemorrhoids
☐	☐	Heartburn
☐	☐	Reflux
☐	☐	Indigestion
☐	☐	Nausea
☐	☐	Pain under ribs – Right side
☐	☐	Pain under ribs – Left Side
☐	☐	Pain under ribs – center
☐	☐	Vomiting
☐	☐	Abnormal liver function tests
☐	☐	Blood in stool
☐	☐	Mucus in stool
☐	☐	Undigested Food in stool
☐	☐	Black / tarry stool
☐	☐	Strong stool odor
☐	☐	Burning Stool sensation
☐	☐	Urgency to bowel movement
☐	☐	Stool incontinence
☐	☐	Incomplete sensation of stool
☐	☐	Ulcers

MUSCULOSKELETAL

☐	☐	Joint Pain
☐	☐	Joint Redness
☐	☐	Joint Stiffness
☐	☐	Foot Cramping
☐	☐	Calf Cramping
☐	☐	Back Muscle Spasm
☐	☐	Muscle Twitching
☐	☐	Muscle weakness
☐	☐	Muscle tightness
☐	☐	Tendonitis
☐	☐	Bursitis
☐	☐	Bone Pains

MENTAL / NEUROLOGICAL

☐	☐	Anxiety
☐	☐	OCD
☐	☐	Depression
☐	☐	Manic
☐	☐	Bipolar
☐	☐	Panic Attacks
☐	☐	Paranoia
☐	☐	Suicidal Thoughts
☐	☐	Hallucinations
☐	☐	Agoraphobia
☐	☐	Black out
☐	☐	Addiction
☐	☐	Rage
☐	☐	Autism Spectrum

Difficulty With:

☐	☐	Concentrating
☐	☐	Balance
☐	☐	Thinking
☐	☐	Speech
☐	☐	Memory

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past	6mo	
☐	☐	Dizziness
☐	☐	Light headedness
☐	☐	Numbness
☐	☐	Siezures
☐	☐	Tremors
☐	☐	Tics
☐	☐	Tingling
☐	☐	Word Finding

EATING

☐	☐	Binge Eating
☐	☐	Bulimia
☐	☐	Anorexia
☐	☐	Gain Weight easily
☐	☐	Lose weight easily
☐	☐	Frequent Dieting
☐	☐	Poor Appetite

SKIN

☐	☐	Acne - back
☐	☐	Acne - chest
☐	☐	Acne – face
☐	☐	Acne – shoulders
☐	☐	Athlete's foot
☐	☐	Bumps on back of upper arms
☐	☐	Cellulite
☐	☐	Dark circles under eyes
☐	☐	Easy bruising
☐	☐	Eczema
☐	☐	Hives
☐	☐	Jock itch
☐	☐	Dull skin
☐	☐	Moles with color/ size change
☐	☐	Oily skin
☐	☐	Dry Skin
☐	☐	Rashes
☐	☐	Red face
☐	☐	Sensitivity to bites
☐	☐	Shingles
☐	☐	Skin darkening
☐	☐	Skin Tags
☐	☐	Strong Body odor
☐	☐	Vitiligo
☐	☐	Purple stretch marks
☐	☐	Plaques
☐	☐	Flaking
☐	☐	Itching

LYMPH NODES ENLARGED

☐	☐	Where?
☐	☐	
☐	☐	

NAILS

☐	☐	Biting
☐	☐	Brittle
☐	☐	Curve up
☐	☐	Frayed
☐	☐	Fungus
☐	☐	Pitting
☐	☐	Ridged
☐	☐	White spots
☐	☐	Dark lines
☐	☐	Red lines

CARDIOVASCULAR

☐	☐	Heart pain / discomfort
☐	☐	Breathlessness
☐	☐	Angina
☐	☐	Heart Murmur
☐	☐	Arrhythmia
☐	☐	Irregular Pulse
☐	☐	Palpitations
☐	☐	Phlebitis
☐	☐	Swollen Ankles/Feet
☐	☐	Varicose Veins
☐	☐	High Blood Pressure
☐	☐	Low Blood Pressure
☐	☐	Fast Heart Beat
☐	☐	Slow Heart Beat
☐	☐	Mitral Valve Prolapse

URINARY

☐	☐	Bed Wetting
☐	☐	Infection –bladder
☐	☐	Infection - kidney
☐	☐	Kidney Disease
☐	☐	Leaking/ Incontinence
☐	☐	Pain or Burning
☐	☐	Urgency
☐	☐	Dribbling at end
☐	☐	Feels incomplete
☐	☐	Hesitancy (trouble starting)
☐	☐	Weak stream
☐	☐	Too light even in morning
☐	☐	Too dark
☐	☐	Scanty amounts

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3. You may also **rate the severity** for each symptom, from **1 (mild), 2 (moderate)** to **3 (severe).**

past	6mo	
☐	☐	Copious amounts
☐	☐	Bladder irritation
☐	☐	Blood in urine
☐	☐	Cloudy urine
☐	☐	Strong Odor
☐	☐	Need to urinate wakes at night
☐	☐	Kidney stones

MALE

☐	☐	Discharge From Penis
☐	☐	Ejaculation Problem
☐	☐	Impotence
☐	☐	Prostate or Urinary Infection
☐	☐	Lumps In Testicles
☐	☐	Poor Sperm Motility
☐	☐	Poor Sperm Morphology
☐	☐	Prostatic Enlargement

FEMALE

☐	☐	Fibrocystic Breasts
☐	☐	Breast Discharge
☐	☐	Breast Lumps
☐	☐	Breast Pain
☐	☐	Ovarian Cysts
☐	☐	Low Libido (Sex Drive)
☐	☐	Vaginal Discharge
☐	☐	Vaginal Odor
☐	☐	Vaginal Itch
☐	☐	Vaginal Pain with Sex
☐	☐	Vaginal Dryness
☐	☐	Fibroids
☐	☐	Endometriosis
☐	☐	PCOS

PREMENSTRUAL SYMPTOMS

☐	☐	Irritability
☐	☐	Anger
☐	☐	Hunger
☐	☐	Breast Tenderness
☐	☐	Breast Swelling
☐	☐	Abdominal Bloating
☐	☐	Cramping
☐	☐	Fatigue
☐	☐	Cold
☐	☐	Heat
☐	☐	Constipation
☐	☐	Diarrhea
☐	☐	Acne

AUTOIMMUNE

☐	☐	Lupus
☐	☐	Hashimoto’s
☐	☐	Guillaune -Barre
☐	☐	Multiple Sclerosis
☐	☐	Autoimmune Hepatitis
☐	☐	Primary Biliary Cirrhosis
☐	☐	Crohn’s Disease
☐	☐	Celiac Disease
☐	☐	Pernicious Anemia
☐	☐	Diabetes Type I
☐	☐	Kawasaki’s Dz
☐	☐	Psoriasis
☐	☐	Scleroderma
☐	☐	Raynaud’s

Please mark any areas of pain or discomfort on the images below.