



Elevation Acupuncture & Herbs

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Patient Health History

Name: _____
Last First Middle Initial

Today's Date: ____/____/____ Date of Birth: ____/____/____

Address: _____

Email: _____

Phone Numbers:(Home) _____ (Work) _____ (Cell) _____

SS#: _____ Age: _____ Height: _____ Weight: _____

Marital Status: Married Single Partner Widow Divorced Other

Referred By: _____

How did you hear about practitioner? _____

Current or Past Occupation: _____

If Employed, Employer's Name & Phone# _____

Primary Care Doctor's Name, Address, & Phone Number: _____

Emergency Contact: _____

Relationship: _____

Phone: _____

Health Insurance Company: _____

Address: _____

Phone Number: _____

Policy Number _____ Group Number _____

Policy Holder's Name & Date of Birth: _____

Employer that Provides Insurance Name: _____

Plan or Program Name: _____

List any Secondary Insurance: _____

Please List Current Conditions in Order of Importance to You	Describe Symptoms:	List All Treatments Received for this Condition:
<p><u>Chief Complaint</u></p>		

Secondary Conditions:		

Attach a separate sheet if you run out of room on the following questions:

List Any Medical Alerts: _____

List Current Medications: _____

List Current Herbs or Supplements: _____

List Types of Exercise & Frequency: _____

List Common Foods Incorporated into Your Diet: _____

List Any Foods You Do Not Eat: _____

Food Allergies: _____

Coffee/Alcohol/Tobacco Intake Per Week: _____

Health Assessment: Please check all that apply

Energy & Sleep: Fatigue Energy fluctuations Hyperactivity

Insomnia or interrupted sleep Difficulty waking in morning

Immune System: Frequent colds/fluës Slow wound healing Chronic

infections Autoimmune Condition: _____

Cardiovascular: High blood pressure Heart Disease Chest Pain

Swelling/ Edema Palpitations/flutterers High Cholesterol

Respiratory: Asthma Shortness of Breath Persistent Cough History

of Pneumonia or Bronchitis Emphysema COPD

Gastrointestinal: Loose stool Constipation Diarrhea Ulcer

Diverticulitis Colitis IBS Celiac's Disease Nausea/Vomiting

Abdominal pain Passing gas Belching Heart burn/GERD

Hemorrhoids Gallbladder disease Liver disease Hepatitis

Urinary-Genital: Frequent urination Painful urination Recurrent UTI

Night time urination Urgent urination Incontinence Blood in urine

Kidney disease Kidney or Bladder Stones

Emotions: Depression Mood swings Anxiety Stress Mental

restlessness Anger Manic episodes

Head, Eyes, Ears, Nose, Throat: Headaches Impaired memory
Mental fogginess Blurry vision Glaucoma Glasses/contacts Red/itchy
eyes Dry eyes Impaired hearing Ear ringing Sinus problems Hay
fever Nose bleeds Frequent sore throats TMJ Teeth grinding

Female Reproductive: Irregular periods Painful periods Heavy flow
 Scanty flow No menses Menopause PMS Breast lumps/tenderness
 Vaginal Discharge Difficulty conceiving , List # of days in cycle _____ , # of
days of flow _____ , # of Pregnancies _____ , # of Live Births _____ , Age of first
menses _____ , Type of birth control: _____

Male Reproductive: Prostate problems Erectile Dysfunction
 Decreased Libido Testicular pain Other _____

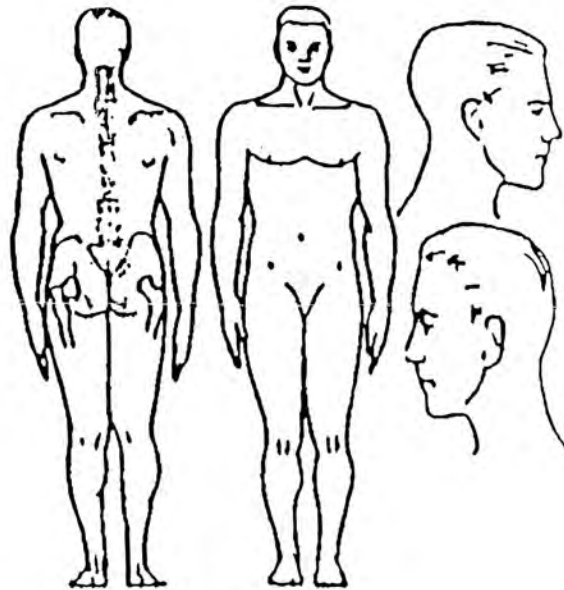
Dermatological: Rashes Eczema Psoriasis Acne Skin Cancer

Endocrine: Hypothyroid Hyperthyroid Hypoglycemia Diabetes
Mellitus Night sweats Feeling hot or cold (please circle which)

Neurological: Vertigo/dizziness Paralysis Numbness/tingling Loss
of balance Seizures/epilepsy Parkinson's Multiple Sclerosis Tremors
 Bell's Palsey Trigeminal Neuralgia Other _____

Musculoskeletal: Neck pain Shoulder pain Arm pain Upper back
pain Mid back pain Low back pain Leg pain Muscle spasms/cramps
 Joint Pain ; Where _____

Please describe the nature of your pain & mark with X on the picture:



Medical History: Please includes dates of past conditions or indicate if currently a problem

List All Significant Illnesses, Allergies, Traumas, or Injuries: _____

Hospitalizations & Surgeries: _____

Infectious Diseases: _____

Family History: Check any conditions close blood relatives have had:

Heart Disease Diabetes Mental Illness Thyroid Problems Cancer

Allergies Respiratory problems High Blood Pressure Stroke

Autoimmune conditions Other _____

Signature

Date