Brian Barlay, L.Ac.

Health History

Date:_____

If you have any questions or if there is anything you wish to bring to my attention, that isn't asked in this form , please let me know. Your personal information is held in strict confidentiality. Thank you for your help.

Name:_____

Ph: (H)_____ (Cell) _____

(W)_____Email:_____

Address:_____

_____zip_____

Date of Birth: _____Age_____

Height:_____Weight:_____Sex:_____

Occupation:_____

Emergency Contact:_____Phone:_____

Referred By:_____

Chief Complaint :_____

When did the problem begin? _____

To what extent does it interfere with daily life? _____

Have you received a diagnosis for the problem? If so, what?_____

What treatment have you been using for relief of this issue?_____

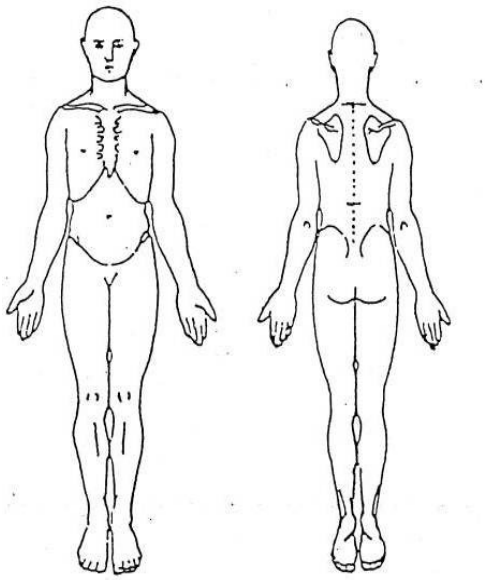
Have you ever received used acupuncture?_____For what reason_____

Severity of problem today; circle # below and area on diagram to right

No Problem 1 2 3 4 5 6 7 8 9 10 Worst Imaginable

Circle severity of problem in general

No Problem 1 2 3 4 5 6 7 8 9 10 Worst Imaginable



Family Medical History— elaborate and indicate which family member

Cancer_____ Heart Disease _____

Diabetes _____ High Blood Pressure _____

Drug/alcohol Abuse _____ Other _____

Other inherited or familial disease:_____

More about you

Surgeries & hospitalizations?_____ Allergies to drugs, chemicals, foods?_____

Stress in your life; chemical, occupational, physical, psychological:_____

What medications, supplements do you take?_____

Weekly exercise?:_____ Please describe your diet:_____

Indicate below your use of the following:

Tobacco _____	per _____	Age started_____	Age quit_____
Caffeine_____	per _____	Age started_____	Age quit_____
Alcohol _____	per _____	Age started_____	Age quit_____
Recreational drugs_____	per _____	Age started_____	Age quit_____
Other_____	per _____	Age started_____	Age quit_____

General

Past Current

- ❑ ❑ Catch colds easily
- ❑ ❑ Recurrent infections
- ❑ ❑ Night sweats
- ❑ ❑ Sweat easily
- ❑ ❑ Bleed or Bruise easily
- ❑ ❑ Strong thirst hot □ cold □
- ❑ ❑ No desire to drink
- ❑ ❑ Fatigue / low energy
- ❑ ❑ Sudden energy drops Time_____
- ❑ ❑ Sudden change in weight

Genito - Urinary

Past Current

- ❑ ❑ Pain on urination
- ❑ ❑ Urgent urination
- ❑ ❑ Frequent urination
- ❑ ❑ Blood in Urine
- ❑ ❑ Change in urinary flow
- ❑ ❑ Urinary incontinence
- ❑ ❑ Dribbling urination
- ❑ ❑ Wake at night to urinate
- ❑ ❑ Recurrent bladder infec-
- ❑ ❑ Recurrent yeast infections
- ❑ ❑ Kidney Stones
- ❑ ❑ Prostrate problems
- ❑ ❑ Change in sexual drive
- ❑ ❑ Impotence
- ❑ ❑ Rashes / Itching

Skin & Hair

Past Current

- ❑ ❑ Dry skin / scalp / hair
- ❑ ❑ Rashes / hives
- ❑ ❑ Itching

Skin & Hair (cont.)

Past Current

- ❑ ❑ Eczema
- ❑ ❑ Warts
- ❑ ❑ Acne
- ❑ ❑ Change in moles
- ❑ ❑ Hair loss / thinning hair
- ❑ ❑ Graying of hair

Sleep

Past Current

- ❑ ❑ Difficult to fall asleep
- ❑ ❑ Wake up easily – times per night_____
- ❑ ❑ Wake too early — times per night_____
- ❑ ❑ Nightmare
- ❑ ❑ Vivid dreams
- ❑ ❑ Grinding teeth
- ❑ ❑ Talking in sleep
- ❑ ❑ Sleepwalking
- ❑ ❑ Snoring
- ❑ ❑ Bad dreams

Cardiovascular

Past Current

- ❑ ❑ Pacemaker
- ❑ ❑ High blood pressure
- ❑ ❑ Low blood pressure
- ❑ ❑ Chest discomfort / pain
- ❑ ❑ Heart palpitations
- ❑ ❑ Cold hands or feet
- ❑ ❑ Swelling of hands or feet
- ❑ ❑ Blood clots
- ❑ ❑ Spider veins
- ❑ ❑ Fainting

Respiratory

Past Current

- ❑ ❑ Pain with breathing
- ❑ ❑ Difficulty with breathing
- ❑ ❑ Shallow breathing
- ❑ ❑ Shortness of breath
- ❑ ❑ Production of phlegm

Respiratory (cont.)

Past Current

- ❑ ❑ Recurrent / chronic cough
- ❑ ❑ Asthma / wheezing
- ❑ ❑ Bronchitis
- ❑ ❑ Emphysema
- ❑ ❑ Pneumonia

Gynecological

Past Current

- ❑ ❑ Irregular periods
- ❑ ❑ Painful periods
- ❑ ❑ Premenstrual syndrome
- ❑ ❑ Menopausal syndrome
- ❑ ❑ Abnormal PAP smear
- ❑ ❑ Abnormal bleeding
- ❑ ❑ Postcoital bleeding
- ❑ ❑ Clots
- ❑ ❑ Fibroids
- ❑ ❑ Endometriosis
- ❑ ❑ Infertility
- ❑ ❑ Vaginal dryness
- ❑ ❑ Vaginal discharge
- ❑ ❑ Vaginal sores
- ❑ ❑ Breast lumps
- ❑ ❑ Nipple discharge

Are you pregnant ? yes □ no □

Do you practice birth control ?
yes □ no □

What type _____

How long _____

# of pregnancies _____

# of births _____

# of premature births _____

# of abortions_____

Age of first menses _____

days between menses _____

Duration of menses _____

1st day of last menses _____

Age of menopause_____

Date of last PAP _____

Neurological

Past Current

- ❑ ❑ Seizures
- ❑ ❑ Paralysis
- ❑ ❑ Tremors
- ❑ ❑ Stroke
- ❑ ❑ Concussion
- ❑ ❑ Nerve Damage
- ❑ ❑ Numbness / tingling
- ❑ ❑ Dizziness / vertigo
- ❑ ❑ Lack of coordination
- ❑ ❑ Loss of balance
- ❑ ❑ Poor memory
- ❑ ❑ Difficulty concentrating

Psychological

Past Current

- ❑ ❑ Depression
- ❑ ❑ Manic Behavior
- ❑ ❑ Anxiety / nervousness
- ❑ ❑ Panic attacks
- ❑ ❑ Often stressed
- ❑ ❑ Easily angered
- ❑ ❑ Easily angered
- ❑ ❑ Aggressive behavior
- ❑ ❑ Lose control of emotions
- ❑ ❑ Substance abuse

Have you been treated for emotional problems? yes ☐ no ☐

Have you ever considered suicide? yes ☐ no ☐

Head/ Eyes / Ears

Past Current

- ❑ ❑ Headaches
- ❑ ❑ Where
- ❑ ❑ When
- ❑ ❑ Migraines

Head / Eyes / Ears Nose / Throat (cont.)

Past Current

- ❑ ❑ Dizziness / vertigo
- ❑ ❑ Earache
- ❑ ❑ Discharge form ear
- ❑ ❑ Change in hearing
- ❑ ❑ Ringing in ears
- ❑ ❑ Blurry vision
- ❑ ❑ Night blindness
- ❑ ❑ Spots before eyes
- ❑ ❑ Sore eyes
- ❑ ❑ Excessive tearing
- ❑ ❑ Glasses / contacts
- ❑ ❑ Facial pain
- ❑ ❑ Nosebleeds
- ❑ ❑ Nasal discharge
- ❑ ❑ TMJ
- ❑ ❑ Teeth / gum problems
- ❑ ❑ Recurrent sore throat
- ❑ ❑ Hoarseness / loss of voice
- ❑ ❑ Tonsillitis / swollen glands
- ❑ ❑ Sores on lips/ mouth/gums

Musculoskeletal

Past Current

- ❑ ❑ Neck pain
- ❑ ❑ Shoulder pain
- ❑ ❑ Back pain
- ❑ ❑ Hand /wrist pain
- ❑ ❑ Knee pain
- ❑ ❑ Foot / ankle pain
- ❑ ❑ Joint / bone problems
- ❑ ❑ Muscle pain / weakness
- ❑ ❑ Osteopenia / osteoporosis
- ❑ ❑ Herniated disc
- ❑ ❑ Sciatica
- ❑ ❑ Other_____

Digestive

Past Current

- ❑ ❑ Little appetite
- ❑ ❑ Strong appetite
- ❑ ❑ Bad Breath
- ❑ ❑ Belching
- ❑ ❑ Nausea
- ❑ ❑ Vomiting
- ❑ ❑ Heartburn
- ❑ ❑ Indigestion
- ❑ ❑ Abdominal Pain
- ❑ ❑ Weight gain
- ❑ ❑ Weight loss
- ❑ ❑ Loose stools / diarrhea
- ❑ ❑ Abnormal stools
- ❑ ❑ Constipation
- ❑ ❑ Gas / flatulence
- ❑ ❑ Gall bladder problems
- ❑ ❑ Hernia
- ❑ ❑ Hemorrhoids
- ❑ ❑ Anorexia nervosa
- ❑ ❑ Bulimia

Infection Screening

Have you ever tested positive? When?

- ❑ HIV _____
- ❑ Tuberculosis_____
- ❑ Hepatitis _____
- ❑ Gonorrhea _____
- ❑ Syphilis _____
- ❑ Herpes (oral / genital)_____