# Sequoyah Acupuncture Clinic

HEALTH HISTORY for WOMEN

Date: ____ / ____ / ______

| Name: | | | Sex: | Age: |
|---|---|---|---|---|
| Address: | City: | | State: | Zip Code: |
| Home Phone #: | Other Phone #: Work Cell Other | Email: | | |
| Date of Birth: | Employer: | Occupation: | | |
| Primary Physician and Phone Number: | Relationship Status: ❐ Single ❐ Married ❐ Separated ❐ Divorced ❐ Widowed ❐ Living w/partner ❐ Other: ___________ | | | |
| Emergency Contact: | Usual Blood Pressure: | | | |
| Weight: | Weight One Year Ago: | How did you hear of our clinic? | | |
| Are you or may you be currently pregnant? | Have you been treated by Acupuncture or Oriental Medicine Before? ❍ No ❍ Yes: when _____/_____/_____ | | | |

## MAIN COMPLAINTS

Please write in your top 3 health complaints / concerns in order of importance to you. Circle the items that make it better or worse and mark on the scale from 1-10 the severity of the condition (1=no symptoms, 10=worst ever)

**1** ____________________________

When did this start? ________________ago

| | | | |
|---|---|---|---|
| Heat makes it: | better | no change | worse |
| Cold makes it: | better | no change | worse |
| Damp weather: | better | no change | worse |
| Exercise / Activity: | better | no change | worse |

1 |———————|———————| 10

**2** ____________________________

When did this start? ________________ago

| | | | |
|---|---|---|---|
| Heat makes it: | better | no change | worse |
| Cold makes it: | better | no change | worse |
| Damp weather: | better | no change | worse |
| Exercise / Activity: | better | no change | worse |

1 |———————|———————| 10

**3** ____________________________

When did this start? ________________ago

| | | | |
|---|---|---|---|
| Heat makes it: | better | no change | worse |
| Cold makes it: | better | no change | worse |
| Damp weather: | better | no change | worse |
| Exercise / Activity: | better | no change | worse |

1 |———————|———————| 10

## HEALTH HISTORY

Check the ❐ if you have / had the condition and note the year it started.
Check the ❍ if there is a family history of the condition.

| | YOU | Year | FAMILY | | YOU | Year | FAMILY |
|---|---|---|---|---|---|---|---|
| Cancer | ❐ | _______ | ❍ | Osteoporosis | ❐ | _______ | ❍ |
| | | | | Herpes | ❐ | _______ | ❍ |
| Diabetes | ❐ | _______ | ❍ | AIDS / HIV | ❐ | _______ | ❍ |
| Hepatitis | ❐ | _______ | ❍ | Other STD | ❐ | _______ | ❍ |
| High Blood Pressure | ❐ | _______ | ❍ | Rheumatic Fever | ❐ | _______ | ❍ |
| Heart Disease | ❐ | _______ | ❍ | Alcoholism | ❐ | _______ | ❍ |
| Stroke | ❐ | _______ | ❍ | Allergies type(s)? ____________ | ❐ | _______ | ❍ |
| Seizure Disorder | ❐ | _______ | ❍ | | | | |
| Thyroid Disease | ❐ | _______ | ❍ | Mental Illness | ❐ | _______ | ❍ |
| Asthma | ❐ | _______ | ❍ | Kidney Disease | ❐ | _______ | ❍ |
| Pacemaker | ❐ | _______ | ❍ | Anemia | ❐ | _______ | ❍ |

## HABITS

| | Amount / Week | If Quit, Year? |
|---|---|---|
| Coffee / Tea | ______________ | _______ |
| Soda | ______________ | _______ |
| Tobacco | ______________ | _______ |
| Alcohol | ______________ | _______ |
| Drugs | ______________ | _______ |

## EXERCISE

Do you exercise regularly? ⑤ Yes ⑤ No

If so, what and how often:

________________________________

________________________________

________________________________

## DIET

Low/No Carb, Vegetarian/Vegan, Portion Control, Low Fat, Standard American

Current or past eating disorder?

## MEDICATIONS

Please note what medications, herbs or supplements that you take regularly

________________________________

________________________________

________________________________

## INJURIES & SURGERIES

Please note what happened to what body area and when it occurred (incl. dental)

________________________________

________________________________

________________________________

# Sequoyah Acupuncture Clinic

HEALTH HISTORY for WOMEN

**Please mark an X on the scales and check any boxes of symptoms you have had in the past month**

## TEMPERATURE

How warm / cold you feel (not in degrees); relative to other people do you wear more or less layers, etc.

COLD |————|————| HOT

- ❒ Cold hands or feet
- ❒ Chills
- ❒ Cold "in the bones"
- ❒ Areas of numbness

Thirst for cold / hot drinks
- ❒ Thirst, no desire to drink
- ❒ Absence of thirst
- ❒ Excessive thirst

- ❒ Night sweats
- ❒ Unusual sweats

When______ am / pm

Where on body ________ _

- ❒ Hot hands, feet, chest
- ❒ Hot flashes
- ❒ Hot in afternoon
- ❒ Hot at night

## MOISTURE

Your overall body moisture (hair, skin, mouth, bowels, etc.)

DRY |————|————| OILY

- ❒ Dry skin
- ❒ Dry hair
- ❒ Dry eyes
- ❒ Dry brittle nails

- ❒ Dry mouth
- ❒ Dry lips
- ❒ Dry throat
- ❒ Dry nose / Nosebleeds

Where on your body?
- ❒ Edema / Swelling ______________
- ❒ Rashes ______________________
- ❒ Itching ______________________
- ❒ Dandruff

- ❒ Oily skin
- ❒ Oily hair
- ❒ Pimples
- ❒ Weight gain / loss

## DIGESTION

DIARRHEA |————|————| CONSTIPATION

BM: How often? _____x / every _____days

Stools keep shape? ❒ Y ❒ N

- ❒ Alternating diarrhea & constipation (IBS)
- ❒ Indigestion

- ❒ Gas
- ❒ Bloating
- ❒ Belching
- ❒ Poor appetite

- ❒ Nausea / Vomiting
- ❒ Bad breath
- ❒ Heartburn
- ❒ Excessive hunger

- ❒ Dry Stools
- ❒ Difficult to pass
- ❒ Tired after BM
- ❒ Foul smelling stools

## ENERGY

LOW |————|————| HIGH

- ❒ Sudden energy drop

Time of day: _____ am / pm
- ❒ Energy drop after eating
- ❒ Fatigue

- ❒ Dependence on caffeine / stimulants
- ❒ Wired / ungrounded feeling
- ❒ Body / Limbs feel heavy
- ❒ Body / Limbs feel weak

- ❒ Shortness of breath
- ❒ Heart Palpitations
- ❒ Blood pressure High / Low
- ❒ Bleed / Bruise easy

- ❒ Hard to concentrate
- ❒ Poor memory
- ❒ Dizziness / lightheaded
- ❒ Headaches _____x / week

## SLEEP

# Hours per night ______
- ❒ Difficulty falling asleep
- ❒ Wake ___x/ night @_____am / pm
- ❒ Wake to urinate: How often? _______
- ❒ Disturbing dreams
- ❒ Restless sleep
- ❒ Not rested upon waking

## EMOTIONS

What emotion(s) dominate your experience?

- ❒ Anger
- ❒ Irritability
- ❒ Anxiety
- ❒ Worry
- ❒ Obsessive thinking
- ❒ Sadness
- ❒ Grief
- ❒ Depression
- ❒ Joy
- ❒ Fear
- ❒ Timid / shy
- ❒ Indecision

## EYES, EARS, NOSE, THROAT

- ❒ Poor vision
- ❒ Night blindness
- ❒ Red eyes
- ❒ Itchy eyes
- ❒ Spots in front of eyes
- ❒ Sinus congestion
- ❒ Phlegm (color________)
- ❒ Poor hearing
- ❒ Ringing in ears
- ❒ Excess earwax
- ❒ Sore throat
- ❒ Dental problems
- ❒ Mouth sores
- ❒ Cough

## MENSES

Age at first menses: ______

Length of full cycle: ______ days (i.e. 28)

Length of menses: ____ days (i.e. 3-4)

Last menses start date: ____ / ____

# of pregnancies: ____

# of births: _______ premature ______

# of abortions / miscarriages: _________

## MENOPAUSE

Age at last menses: ________

Year changes began: _______

- ❒ Hot flashes _____x / day
- ❒ Night sweats _____x / week
- ❒ Vaginal dryness
- ❒ Loss of sex drive

- ❒ Heavy periods
- ❒ Light periods
- ❒ Painful periods
- ❒ Irregular periods
- ❒ Changes in body/ psyche prior to menstruation (PMS)

- ❒ Cramps
- ❒ Before bleeding
- ❒ First day
- ❒ During period
- ❒ Clots
- ❒ Breast tenderness

- ❒ Mood changes
- ❒ Fatigue w/ menses
- ❒ Digestive changes w/ menses
- ❒ Mid-cycle spotting
- ❒ Yeast infections
- ❒ Birth control pill (hormonal)