Sequoyah Acupuncture Clinic

HEALTH HISTORY for MEN

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 MEN

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.

Hemorrhoids

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

URINARY

Fluid in = fluid out? ❒ Y ❒ N

- ❒ Decrease in flow
- ❒ Dribbling
- ❒ Difficulty starting / stopping
- ❒ Incontinence
- ❒ Kidney stones

- ❒ Urgency to urinate
- ❒ Frequent urination
- ❒ Pain on urination
- ❒ Burning sensation
- ❒ Cloudy urine
- ❒ Blood in urine

REPRODUCTIVE

Are you sexually active? ❒ Y ❒ N

- ❒ Change of sexual drive: ↑ ↓
- ❒ Erectile dysfunction
- ❒ Premature ejaculation
- ❒ Sores on genitals
- ❒ Discharge

- ❒ Prostate disease
- ❒ Genital Pain
- ❒ Jock Itch
- ❒ Vasectomy
- ❒ Hernia
- ❒