Mountain Spirit Acupuncture
12201 Pecos Street Suite 100 Westminster, CO 80234
303-929-7334

Patient Health History (Female)

Name: _____ Birth Date: _____/_____/_____ Age: _____

Address: _____ City: _____ State: _____ Zip: _____

Preferred Phone #: _____ □ Home □ Cell □ Work Ok to leave messages? □ Yes □ No

How did you hear about **Mountain Spirit Acupuncture?** □ Friend – (Who?) _____ □ Internet
□ Mail-out □ MD / Midwife □ Other _____

Emergency Contact: _____ Relation: _____ Phone #: _____

Successful health care is only possible when the practitioner has a thorough understanding of the patient physically, mentally and emotionally. Please complete the following questionnaire as thoroughly as possible.

Are you currently receiving health care? □ Yes □ No
If yes, where and from whom? _____
If no, when and where did you last receive health care? _____

MAIN HEALTH CONCERNS

PRIMARY COMPLAINT: _____
Symptoms: _____
_____
_____
How long have you had this? _____
Is your condition: □ Getting worse □ Staying constant □ Coming & going Have you had this in the past? □ Yes □ No
How did it begin? _____
What aggravates it? _____
What relieves it? _____
What other healthcare practitioners have you seen about this? _____
Type of care given? _____ Was it effective? _____

SECONDARY COMPLAINT: _____
Symptoms: _____
_____
_____
How long have you had this? _____
Is your condition: □ Getting worse □ Staying constant □ Coming & going Have you had this in the past? □ Yes □ No
How did it begin? _____
What aggravates it? _____
What relieves it? _____
What other healthcare practitioners have you seen about this? _____
Type of care given? _____ Was it effective? _____

Are your complaints affecting your ability to work or otherwise be active? □ No effect □ Yes □ Some physical restrictions
□ Need limited assistance □ Need assistance often □ Can't care for self

Is today's visit due to a Motor Vehicle Collision? □ Yes □ No If yes, when? _____
Have you ever had acupuncture before? □ Yes □ No
Do you have any chronic infections diseases? □ Yes □ No If yes, explain: _____
Are you suffering from any chronic illnesses? □ Yes □ No If yes, explain: _____

Significant diseases, injuries, hospitalizations, surgeries, x-ray/CT/MRI/NMR

Reason Date Results (if applicable)

_____

_____

_____

_____

Please list any prescription medications, over the counter medications, vitamins or supplements that you are currently taking, and give your dosage.

Medication/Vitamin/Supplement Dosage Frequency Reason

_____

_____

_____

_____

_____

Please list any foods, drugs, substances or medications you are hypersensitive or allergic to: _____

Please check any immunizations that you have had: □ Polio □Tetanus □ Measles/Mumps/Rubella (MMR) □ Pertussis □ Diphtheria □ Hepatitis B □ Influenza □ Other: _____

Family History	Mother	Father	Brother(s)	Sister(s)
Age if living				
Health G = Good, P = Poor				
Age at death if deceased				
Cause of death				
Family Illnesses	Mother	Father	Brother(s)	Sister(s)
Allergies				
Cancer				
Diabetes				
Heart Disease				
High Blood Pressure				
Kidney Disease				
Stroke				
Mental Illness				

HEALTH HISTORY

When completing the information below, indicate if it is a CURRENT condition (first box) or a PAST condition (second box):

General Symptoms

C / P
- □ □ Poor appetite
- □ □ Large appetite
- □ □ Strongly like cold drinks
- □ □ Strongly like hot drinks
- □ □ Peculiar taste
- □ □ Cravings
- □ □ Sweats easily
- □ □ Night sweats
- □ □ Prolapsed organs

C / P
- □ □ Poor Sleep
- □ □ Dream disturbed sleep
- □ □ Heavy sleep
- □ □ Bodily heaviness
- □ □ Chills
- □ □ Fever
- □ □ Bleed or bruise easily
- □ □ Cold hands or feet

C / P
- □ □ Poor circulation
- □ □ Vertigo or dizziness
- □ □ Fatigue
- □ □ Lack of strength
- □ □ Shortness of breath
- □ □ Muscle cramps
- □ □ Anemic
- □ □ History of Cancer

  What type: _____ When: _____

Endocrine and Metabolic Disorders
- □ □ Hypothyroidism
- □ □ Adrenal burnout / fatigue
- □ □ Sweats easily
- □ □ Hyperthyroidism
- □ □ Diabetes Mellitus
- □ □ Weight gain
- □ □ Hypoglycemia
- □ □ Night sweats
- □ □ Weight loss

Head, Eyes, Ears, Nose, Throat

C / P
- □ □ Headaches
- □ □ Migraines
- □ □ Facial pain
- □ □ Glasses or Contacts
- □ □ Poor vision
- □ □ Blurred vision
- □ □ Eye strain
- □ □ Red eyes
- □ □ Itchy eyes
- □ □ Spots or floaters in eyes

C / P
- □ □ Glaucoma
- □ □ Night blindness
- □ □ Sores on lips or tongue
- □ □ Swollen glands
- □ □ Dry mouth
- □ □ Excessive saliva
- □ □ Recurrent sore throat
- □ □ Lumps in throat
- □ □ TMJ problems
- □ □ Teeth problems

C / P
- □ □ Grinding teeth
- □ □ Sinus problems
- □ □ Enlarged thyroid
- □ □ Excessive phlegm
- □ □ Ear aches
- □ □ Ringing in ears
- □ □ Poor hearing
- □ □ Gum problems
- □ □ Eye pain
- □ □ Concussions

Respiratory
- □ □ Difficulty breathing when lying down
- □ □ Shortness of breath
- □ □ Tight chest
- □ □ Cough Wet or dry (circle one)
- □ □ Color of phlegm _____
- □ □ Coughing blood
- □ □ Asthma / Wheezing
- □ □ Pneumonia
- □ □ Frequent colds
- □ □ Persistent cough

Cardiovascular
- □ □ High blood pressure
- □ □ Tight chest
- □ □ Chest pain
- □ □ Pace maker
- □ □ Fainting
- □ □ Difficulty breathing
- □ □ Heart palpitations
- □ □ Low blood pressure
- □ □ Irregular heart beat
- □ □ Heart disease
- □ □ Blood clots

Are you currently taking Coumadin, Warfarin or any other blood thinners? □ Yes □ No

Gastrointestinal

Bowel movements:
Frequency: _____
Texture/Form: _____
Color: _____
Odor: _____
- □ □ Diarrhea
- □ □ Constipation
- □ □ Laxative use
- □ □ Mucous in stool
- □ □ Undigested food in stool
- □ □ Itchy anus
- □ □ Anal fissures
- □ □ Black stools
- □ □ Bloody stools
- □ □ Gas
- □ □ Bloating
- □ □ Intestinal pain or cramping
- □ □ Burning anus
- □ □ Rectal pain
- □ □ Fatigue after eating
- □ □ Hemorrhoids
- □ □ Nausea
- □ □ Vomiting
- □ □ Acid regurgitation / Heart burn
- □ □ Bad breath
- □ □ Frequent hiccups
- □ □ Gallbladder disease
- □ □ Liver disease
- □ □ Incomplete bowel movement

Skin and Hair
- □ □ Rashes
- □ □ Eczema
- □ □ Dandruff
- □ □ Hair loss
- □ □ Change in hair / skin texture
- □ □ Hives
- □ □ Psoriasis
- □ □ Itching
- □ □ Fungal infections
- □ □ Ulcerations
- □ □ Acne

Neuropsychological
- □ □ Seizures
- □ □ Poor Memory
- □ □ Irritability
- □ □ Stroke
- □ □ Mental tension
- □ □ Considered or attempted suicide
  When: _____
- □ □ Numbness
- □ □ Depression
- □ □ Easily stressed
- □ □ Mood swings
- □ □ Anger easily
- □ □ Tics
- □ □ Anxiety
- □ □ Abuse survivor
- □ □ Mental fogginess
- □ □ Loss of balance
- □ □ Paralysis

Genito-Urinary
- □ □ Pain when urinating
- □ □ Blood in urine
- □ □ Venereal disease
- □ □ Increased libido
- □ □ Urgency to urinate
- □ □ Frequent urination
- □ □ Bed wetting
- □ □ Unable to hold urine
- □ □ Decreased libido
- □ □ Difficulty urinating
- □ □ Wake to urinate
- □ □ Incomplete urination
- □ □ Kidney stone
- □ □ Incontinence

Urinary output equal to liquid intake? □ Yes □ No

Musculoskeletal pain Please fill out the Pain Management Intake

Your diet

Appetite: □ Low □ Strong □ Too busy to notice

C / P

□ □ Coffee (#/day) _____
□ □ Soft drinks (#/day) _____
□ □ Water (#/day) _____
□ □ Frequent thirst

C / P

□ □ Artificial sweeteners
□ □ Red meat
How frequently: _____
□ □ Decreased thirst

C / P

□ □ Energy Drinks
□ □ Dairy
How frequently: _____

Yesterday's breakfast: _____ Lunch: _____
Dinner: _____ Snacks: _____ Is this a typical day? □ Yes □ No

Your lifestyle

□ □ Alcohol
How often? _____
□ □ Marijuana
How often? _____
□ □ Tobacco
How much? _____
□ □ Occupational hazards
□ □ Other recreational drug use
□ □ Exercise Type: _____ Frequency: _____
□ □ Stress Cause: _____
Occupation: _____ Hours/week: _____ Do you enjoy your job? □ Yes □ No

Your sleep

□ □ Difficulty falling asleep
□ □ Difficulty staying asleep
□ □ Wake feeling rested
□ □ Vivid dreams
□ □ Good sleep quality
□ □ Poor sleep quality
□ □ Frequent waking What time: _____ For how long: _____

Menstrual History

Age menses began: _____
Age menopause began: _____
Date of last menstrual period: _____
Are you pregnant, or is there a chance you are pregnant? □ Yes □ No
If yes, how many weeks? _____
Are your periods painful? □ Yes □ No
If so, how many days does the pain last? _____
What is the quality of pain? □ Sharp □ Dull □ Burning □ Cramping
□ Fixed □ Moving
How many days do you typically bleed? _____
How heavy is the bleeding? □ Light □ Moderate □ Heavy
What day is the heaviest? _____
What color is the blood? □ Light red □ Red □ Dark red
□ Brown □ Black
Is there clotting? □ Yes □ No if yes, what size: _____
Average number of days in your cycle? _____
Do you bleed or spot between periods? □ Yes □ No
Do you have premenstrual tension? □ Yes □ No
Does your face break out before your period? □ Yes □ No
Does your face break out during your period? □ Yes □ No
Do you have premenstrual breast tenderness? □ Yes □ No
Do you retain water during your period? □ Yes □ No
Do you get premenstrual low back pain? □ Yes □ No
Do you have loose bowel movements at the beginning of your period? □ Yes □ No
Have your cycles changed since they began? □ Yes □ No
If yes, describe:_____
_____
Do you ovulate on your own? □ Yes □ No
On what day of your cycle? _____
Do your breasts get tender at/during ovulation? □ Yes □ No
Date of last pap smear: _____
Have you ever had an abnormal pap smear? □ Yes □ No

Number & years:
Pregnancies: _____
Children (age and gender):_____
_____
Abortions: _____
Miscarriages: _____
D&C or D&E: _____
Complications: _____

Do you get yeast infections regularly? □ Yes □ No
Have you ever had a venereal disease? □ Yes □ No
Have you ever been diagnosed with Chlamydia? □ Yes □ No
Do you have chronic vaginal discharge? □ Yes □ No
If yes, what color?_____
Does it have a smell? □ Yes □ No
If yes, what does it smell like? _____
Have you ever had pelvic inflammatory disease? □ Yes □ No
If yes, were you treated for it? □ Yes □ No
Treatment method: _____
_____
Have you ever been diagnosed with uterine fibroids or polyps? □ Yes □ No
Have you ever been diagnosed with endometriosis? □ Yes □ No
Have you been diagnosed with pelvic adhesions or abnormalities? □ Yes □ No
Have you been diagnosed with PCOS (Poly Cystic Ovary Syndrome)? □ Yes □ No
Have you taken any medications other than contraceptives for gynecological conditions? □ Yes □ No

Medication	Reason	How long?

Is there anything else about you or your health history you feel we should know about? _____
_____