H. Edward Strozier, L.Ac., M.Ac., Dipl.Ac.
Health History Form

Name____ Birthday_______________ Age_______ Gender____________

Address ________________________________ City ______________________________ State________ Zip______________

Home Phone________________________ Cell Phone________________________ Work Phone__________________________

Email____ Height_____________ Weight_____________________

Married Single Partner Divorced Widowed   Children (Age & Gender)____

Family Physician_____________________________ Phone_____________________ Referred by________________________

Emergency Contact___________________________ Phone_____________________ Relationship_______________________

I. Goals: What would you like to address through treatment?

____

____

II. Medications / Supplements
Medications you are currently taking (please include prescription medicine, supplement, herbal supplements and over the counter medicines you take on a regular basis, along with dosages and brands if known)

_________________________________   _________________________________   _________________________________
_________________________________   _________________________________   _________________________________
_________________________________   _________________________________   _________________________________

Allergies (to medications, chemicals or foods):____

III. Lifestyle
1. What is your occupation?__________________________________ How many hours do you work weekly?__________

2. How many servings per day do you use of the following?
Coffee________ tea__________ soft drinks________ Alcohol_________ Water_________________
Cigarettes , cigars, or other tobacco____

3. Do you have a known history of any exposure to *toxic* substances? [ ] Yes [ ] No

4. Please describe your current exercise regimen:
Hours per week: ______ Activities: ____ [ ] No Exercise

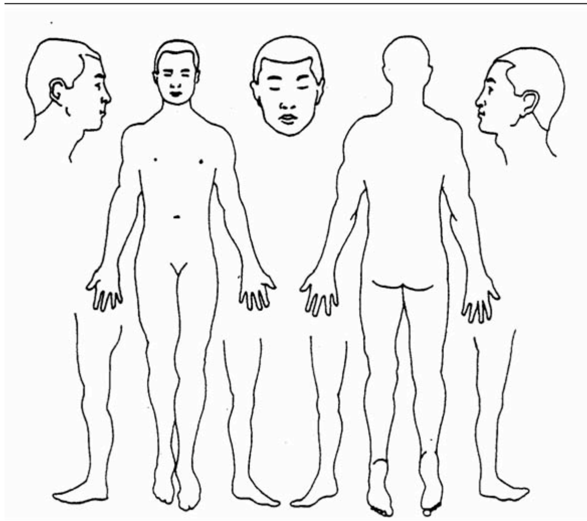
5. How many hours of sleep do you usually get per night during the week? ______________
Do you awake feeling rested? [ ] Yes [ ] No   Do you sleep soundly? [ ] Yes [ ] No
Do you get up at night to urinate? [ ] Yes [ ] No   How often?_____________

For Women:
1. Age: First period _____Menopause (if applicable) ____ 4. Date: Last Pap Smear _____ Last Mammogram _______
a) Average number of days of flow ______ b) The flow is: [ ] Normal [ ] Heavy [ ] Light
c) The color is: [ ] Normal [ ] Dark [ ] Purple [ ] Light Brown [ ] Brown d) Time between periods:______
2. Are you pregnant now? [ ]Yes [ ]No [ ]Unsure
3. Indicate number of occurrences: Live Births ______ Pregnancies_______

For Men:
1. Do you have any bothersome urinary, genital, or sexual symptoms? [ ] Yes [ ] No
Describe:____

IV. Pain

Use the following illustration to indicate painful or distressed areas:



Are you experiencing pain/discomfort in any area of your body? **Y / N**

If yes, using the models to the left, please indicate the location of the discomfort by using the symbol that best describes the feeling:

X X X Sharp/stabbing
P P P Pins & Needles
D D D Dull/Aching
N N N Numbness

V. Recent Hospitalizations / Surgical History

____Date _______

____Date________

____Date________

Other relevant information:
____
____
____

HEALTH: CHECK ALL THAT APPLY

GENERAL

Past	*Current*	*Condition*
[ ]	[ ]	Poor appetite
[ ]	[ ]	Excessive appetite
[ ]	[ ]	Insomnia
[ ]	[ ]	Fatigue
[ ]	[ ]	Fevers
[ ]	[ ]	Night sweats
[ ]	[ ]	Sweat easily
[ ]	[ ]	Chills
[ ]	[ ]	Localized weakness
[ ]	[ ]	Strong Thirst
[ ]	[ ]	Bleed or bruise easily
[ ]	[ ]	Catch cold easily
[ ]	[ ]	Change in appetite

CARDIOVASCULAR

Past	*Current*	*Condition*
[ ]	[ ]	High blood pressure
[ ]	[ ]	Low blood pressure
[ ]	[ ]	Blood clots
[ ]	[ ]	Palpitations
[ ]	[ ]	Phlebitis
[ ]	[ ]	Chest pain
[ ]	[ ]	Irregular heart beat
[ ]	[ ]	Cold hands / feet
[ ]	[ ]	Fainting
[ ]	[ ]	Difficult breathing
[ ]	[ ]	Swelling of hands / feet
[ ]	[ ]	Other: _____________

FEMALE

Past	*Current*	*Condition*
[ ]	[ ]	Frequent urinary tract infections
[ ]	[ ]	Frequent vaginal infections
[ ]	[ ]	Pain / itching of genitalia
[ ]	[ ]	Genital lesions / discharge
[ ]	[ ]	Pelvic inflammatory disease
[ ]	[ ]	Abnormal pap smear
[ ]	[ ]	Irregular menstrual periods
[ ]	[ ]	Painful menstrual periods
[ ]	[ ]	Premenstrual syndrome
[ ]	[ ]	Abnormal bleeding
[ ]	[ ]	Menopausal syndrome
[ ]	[ ]	Breast lumps
[ ]	[ ]	Hot flashes

SKIN & HAIR

Past	*Current*	*Condition*
[ ]	[ ]	Rashes
[ ]	[ ]	Hives
[ ]	[ ]	Itching
[ ]	[ ]	Eczema
[ ]	[ ]	Pimples
[ ]	[ ]	Dryness
[ ]	[ ]	Tumors, lumps

HEAD & NECK

Past	*Current*	*Condition*
[ ]	[ ]	Dizziness
[ ]	[ ]	Fainting
[ ]	[ ]	Neck stiffness
[ ]	[ ]	Enlarged lymph glands
[ ]	[ ]	Headaches
[ ]	[ ]	Concussions
[ ]	[ ]	Other: ______________

EARS

Past	Current	Condition
[ ]	[ ]	Infection
[ ]	[ ]	Ringing
[ ]	[ ]	Decreased hearing
[ ]	[ ]	Other: _____________

EYES

Past	*Current*	*Condition*
[ ]	[ ]	Blurred vision
[ ]	[ ]	Visual changes
[ ]	[ ]	Poor night vision
[ ]	[ ]	Spots
[ ]	[ ]	Cataracts
[ ]	[ ]	Glasses / contacts
[ ]	[ ]	Eye inflammation
[ ]	[ ]	Other: _____________

NOSE, THROAT, MOUTH

Past	*Current*	*Condition*
[ ]	[ ]	Nose bleeds
[ ]	[ ]	Sinus infections
[ ]	[ ]	Hay fever or allergies
[ ]	[ ]	Recurring sore throats
[ ]	[ ]	Grinding teeth
[ ]	[ ]	Difficulty swallowing

RESPIRATORY

Past	*Current*	*Condition*
[ ]	[ ]	Asthma
[ ]	[ ]	Bronchitis
[ ]	[ ]	Frequent colds
[ ]	[ ]	Chronic obstructive
[ ]	[ ]	Pulmonary disease
[ ]	[ ]	Pneumonia
[ ]	[ ]	Cough
[ ]	[ ]	Coughing blood
[ ]	[ ]	Production of phlegm
[ ]	[ ]	Other: ______________

GASTRO-INTESTINAL

Past	*Current*	*Condition*
[ ]	[ ]	Nausea
[ ]	[ ]	Vomiting
[ ]	[ ]	Diarrhea
[ ]	[ ]	Belching
[ ]	[ ]	Blood in stools/black
[ ]	[ ]	Stools
[ ]	[ ]	Bad breath
[ ]	[ ]	Rectal pain
[ ]	[ ]	Hemorrhoids
[ ]	[ ]	Constipation
[ ]	[ ]	Pain or cramps
[ ]	[ ]	Indigestion
[ ]	[ ]	Gall bladder disorder
[ ]	[ ]	Gas
[ ]	[ ]	Other: _____________

GENITO-URINARY

Past	*Current*	*Condition*
[ ]	[ ]	Kidney stones
[ ]	[ ]	Pain or urination
[ ]	[ ]	Frequent urination
[ ]	[ ]	Blood in urine
[ ]	[ ]	Urgency to urinate
[ ]	[ ]	Incontinence
[ ]	[ ]	Other: _________

MALE

Past	*Current*	*Condition*
[ ]	[ ]	Pain / itching genitalia
[ ]	[ ]	Genital lesions/ discharge
[ ]	[ ]	Impotence
[ ]	[ ]	Weak urinary stream
[ ]	[ ]	Lumps in testicles
[ ]	[ ]	Other: _________

NEUROLOGICAL

Past	*Current*	*Condition*
[ ]	[ ]	Seizures
[ ]	[ ]	Tremors
[ ]	[ ]	Numbness/tingling of limbs
[ ]	[ ]	Concussion
[ ]	[ ]	Pain
[ ]	[ ]	Paralysis
[ ]	[ ]	Other: __________________

PSYCHOLOGICAL

Past	*Current*	*Condition*
[ ]	[ ]	Depression
[ ]	[ ]	Anxiety / stress
[ ]	[ ]	Irritability
[ ]	[ ]	Treated for emotional or
[ ]	[ ]	Psychological problems
[ ]	[ ]	Suicidal Thoughts

INFECTION SCREENING

Past	*Current*	*Condition*
[ ]	[ ]	HIV
[ ]	[ ]	TB
[ ]	[ ]	Hepatitis
[ ]	[ ]	Gonorrhea
[ ]	[ ]	Chlamydia
[ ]	[ ]	Syphilis
[ ]	[ ]	Genital warts
[ ]	[ ]	Herpes: oral
[ ]	[ ]	Herpes: genital

MUSCULAR-SKELETAL

Past	*Current*	*Condition*
[ ]	[ ]	Stiff neck / shoulders
[ ]	[ ]	Low back pain
[ ]	[ ]	Back pain
[ ]	[ ]	Muscle spasm, twitching, cramps
[ ]	[ ]	Sore, cold or weak knees
[ ]	[ ]	Joint pain