Coastal Acupuncture
& Natural Health Center

Healing the whole person
Balancing mind, body, & spirit

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Coastal Acupuncture & Natural Health Center
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Wellness History

Name: _____ **Age:** _____

Present Health Concerns (in order of importance): **Duration:**
1. _____ _____
2. _____ _____
3. _____ _____

MEDICAL/HEALTH HISTORY:

Current Health Provider(s): Phone: Reason for seeing:
_____ (____)_____ _____
_____ (____)_____ _____

Date of last full physical exam:_____ Results: normal other (_____)
Date of last labwork and urine test:_____ Results: normal other (_____)
Date of last prostate exam (males):_____ Results: normal other (_____)
Date of last PAP and pelvic exam (females):_____ Results: normal other (_____)
Date of last mammogram (females):_____ Results: _____
Date of last DEXA or bone imaging (females):_____ Results: _____

Surgeries with Dates:_____
Hospitalizations with Dates:_____
Illnesses with Dates: _____
Injuries with Dates:_____
Allergies (drugs, food, environmental). Please **circle** any, if life-threatening:_____
Prescription Drugs (include dosage): _____
_____
Supplements: _____
Previous Holistic Treatments:_____

MEDICAL/FAMILY HISTORY:

Condition	Self/Family Member
Allergies	
Alcoholism	
Anemia	
Rheumatoid Arthritis	
Osteo Arthritis	
Diabetes	
Cancer ( )	
High Cholesterol	
Epilepsy	
Heart disease	

Condition	Self/Family Member
Kidney disease	
Mental disorder	
Obesity	
Stroke	
Thyroid (low/high)	
Osteoporosis	
Fractures (Mom/Grandma)	
Autoimmune Disease	
Bleeding Tendency	
High Blood Pressure	

SOCIAL HISTORY

Personal Habits (Please List Current or Past Use, Frequency, and Quantity):
Tobacco: _____ Caffeine: _____ Alcohol: _____ Recreational Drugs: _____

EXERCISE: List Type of Activities:_____ Frequency per week:_____

Diet History (include any liquids, tea, coffee, etc.):
Breakfast yesterday: _____ AM Snack foods:_____

Lunch yesterday: _____ PM Snack foods: _____

Dinner yesterday: _____ Late PM Snack foods: _____

Bars/Shakes: _____ Glasses or Ounces of plain water intake/day: _____

Please List Any Dietary Restrictions: _____

What level of change to your living habits are you willing to make to improve your overall well-being?

❑ Whatever It Takes ❑ Significant Change ❑ Some Change ❑ No Change

REVIEW OF SYSTEMS (**check** if you **now have** or **circle** if you **previously have had** any of the following):

Hematologic:
- ❑ Anemia
- ❑ Blood diseases
- ❑ Fatigue
- ❑ Dizziness
- ❑ Excessive bleeding
- ❑ Abnormal bruising
- ❑ Blood clots

Skin/Nails:
- ❑ Skin rash/hives
- ❑ Brittle nails

HEENT:
- ❑ Headaches
- ❑ Hearing loss
- ❑ Ringing in the ears
- ❑ Vision loss/changes
- ❑ Eye pain/Itchy eyes
- ❑ Sore throat
- ❑ Sneezing/runny nose
- ❑ Nosebleeds
- ❑ Sinusitis
- ❑ Jaw Pain (TMJ)
- ❑ Mouth/tongue sores
- ❑ Catch colds easily

Gastrointestinal:
- ❑ Bad breath
- ❑ Ulcers
- ❑ Constipation
- ❑ Heartburn
- ❑ Stomach Ulcers
- ❑ Diarrhea
- ❑ Nausea
- ❑ Vomiting
- ❑ Rectal itching
- ❑ Hemorrhoids
- ❑ Hepatitis/Jaundice
- ❑ Bitter taste in mouth
- ❑ Burping
- ❑ Gas
- ❑ Cramping
- ❑ Bloating
- ❑ Laxative use
- ❑ Blood in stools

Frequency of BM_____

Color of stool _____

Musculokskeletal:
- ❑ Difficulty walking
- ❑ Muscular pain

Cardiovascular:
- ❑ Stroke
- ❑ Nosebleeds
- ❑ Varicose veins
- ❑ High/Low blood pressure
- ❑ Chest pain
- ❑ Heart Disease
- ❑ Irregular heart beat
- ❑ Swelling/edema
- ❑ Cold hands/feet
- ❑ Varicose veins

Neuro-psychiatric:
- ❑ Tingling
- ❑ Weakness
- ❑ Numbness
- ❑ Seizures
- ❑ Paralysis
- ❑ Poor balance
- ❑ Poor memory
- ❑ Poor concentration
- ❑ Depression
- ❑ Anxiety
- ❑ Eating disorder

Respiratory:

Genitourinary:
- ❑ Kidney Infection
- ❑ UTI
- ❑ Kidney Disease/Stones
- ❑ Blood in urine
- ❑ Frequent urination
- ❑ Night time urination
- ❑ Incontinence
- ❑ Testicular pain or mass
- ❑ Prostate problem
- ❑ Sexual dysfunction
- ❑ STD _____

Gynecological:
- ❑ Menopause
- ❑ Breast lump
- ❑ Breast discharge
- ❑ PMS

Age period started: _____

LMP _____

Periods last _____days

Periods come every _____days
- ❑ Pain with periods
- ❑ Heavy menstrual bleeding

Number of pregnancies _____

Systemic Review:
- ❑ Hot flashes
- ❑ Night sweats
- ❑ Excessive Thirst
- ❑ Fever
- ❑ Joint Pain/stiffness
- ❑ Muscular Weakness

Endocrine:
- ❑ Hair loss/thinning
- ❑ Dry Skin
- ❑ Tuberculosis
- ❑ Asthma/wheezing
- ❑ Difficulty breathing
- ❑ Cough
- ❑ Pneumonia

Number of living children _____

Number of miscarriages _____

Number of abortions _____
- ❑ Vaginal discharge
- ❑ Vaginal itching

❑ Chills ❑ Hormone therapy ❑ Other:_____ Currently pregnant? Yes No

Sleep: Hours/night: _____ Bedtime: _____ Waketime:_____

Do you have problems with: ❑ Difficulty remembering dreams ❑ Nightmares ❑ Staying asleep
❑ Waking up in the am ❑ Waking refreshed ❑ Falling asleep

Do you wake up at night? If yes, how often and at what times does this happen? _____

Energy level (average per week, **circle one**): (lowest energy) 1 2 3 4 5 6 7 8 9 10 (highest energy)

Stress level (average per week, **circle one**): (lowest stress) 1 2 3 4 5 6 7 8 9 10 (highest stress)

Sources of stress: _____ How do you cope with stress? _____

Pain Level (average per day, circle one) : (lowest pain) 1 2 3 4 5 6 7 8 9 10 (highest pain)

Areas of Pain:

Please list all areas of pain:_____