

The Healing House of Alachua

14804 NW 140th Street, Alachua, FL 32615
386-462-0020 www.healinghousealachua.com

Patient Information Form

Name: _____ Date: _____

Address: _____ City: _____ State & Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Email Address: _____ Occupation: _____

Business Address: _____ City: _____ State & Zip: _____

Place of Birth: _____ Date of Birth: _____ Age: _____ Height: _____ Weight: _____

Sex: _____ Male _____ Female Marital Status: (Single, Married, Life Partner, Divorced, Widowed, other)

Contact In Case of Emergency:

Name: _____ Address: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

How did you hear about our clinic? _____

When and where did you last receive health care? _____

Have you utilized acupuncture and Chinese medicine prior to coming to our clinic? Yes No

Do you have any reason to believe you may be pregnant? Yes No If so, how far along are you? _____

Do you have any infectious diseases? Yes No If yes, please identify the condition: _____

Has your medical case been referred to an attorney? Yes No

Please list your primary health complaints/concerns. Please rate the extent to which your current complaints affect your daily life (1=minor, 10=major): _____

Please rate your commitment to resolving your problems (1=minor, 10=major): _____

Please list any medications (including natural remedies) you are currently taking or attach a list: _____

Please list any known allergies to food, herbs, or medications: _____

List any and all previous “significant health events” in chronological order (include surgeries, traumas, illnesses):

<u>Health Event</u> <i>Ex. Concussion from bicycle accident</i>	<u>Age Occurred</u> <i>5 years old</i>
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	
9.	
10.	
11.	
12.	
13.	
14.	
15.	

General Health Assessment: Please check those symptoms that apply. Please include all symptoms or conditions that you suffer from, including those you are currently taking medications for. Example: if you take a drug for hypertension and even though it is controlled, please include that as one of your complaints.

Family's Medical History Only:

(Please indicate just your family history of diseases below, not your current history)

- Alcoholism
- Asthma
- Allergies/Hay fever
- Cancer
- Degenerative conditions (MS, etc)
- Diabetes
- Heart disease
- Hepatitis
- High Blood Pressure
- Infectious disease
- Kidney disease
- Lyme disease
- Mental illness: _____
- Rheumatic Fever
- Parkinson's disease
- Seizures
- Stroke
- Thyroid disorders
- Tuberculosis
- Venereal disease
- Other family illnesses: _____

Personal Birth-Childhood History:

- Alcohol/drugs used by mother prior or during pregnancy
- Alcohol/drugs used by father prior to pregnancy
- Mother and/or father exposed to toxins before conception or during pregnancy
- Venereal disease by mother or father prior to pregnancy
- Emotional or physical trauma suffered by mother during pregnancy
- Illness of mother during pregnancy. (Please list): _____
- Poor nutrition by mother prior or during pregnancy
- Medication used by mother during pregnancy (Please list): _____
- Mother smoked or exposed to second hand smoke
- Prior miscarriage by mother before pregnancy: _____
- Late delivery
- Premature delivery
- Rapid labor by mother
- Slow, long labor by mother
- Induction of labor
- Epidural by mother during labor

- High forceps
- Breech birth
- Cord wrapped around neck
- Cesarean section
- Placenta previa
- Birth weight in lbs: _____
- Spent time in incubator after birth
- Jaundiced as an infant
- Mother hospitalized after childbirth beyond usual post-delivery
- Bottle-fed
- Breastfed by mother
- Colic
- APGAR score _____
- Number of siblings: _____
- Position among your siblings: _____
- Health during childhood (good, fair, poor)
- Slow or delayed development
- Childhood obesity
- ADD/ADHD
- Hyperactivity
- Learning disabilities: _____
- Physical, emotional, sexual abuse
- Sleep patterns during childhood: _____
- Illnesses or hospitalizations in childhood: _____
- Vaccine reactions: _____

Please fill out the next section as thoroughly as possible. Speak to other family members. This information may come as family anecdotes.

Ears, Eyes, & Mouth Health:

- Ear discharge
- Ear pain
- Ear infection history: _____
- Hearing loss
- Ringing in the ears (tinnitus)
- Cataracts
- Conjunctivitis
- Dry, itchy, watery eyes
- Double Vision
- Eye stress, easily fatigued
- Floaters (spots in visual field). *Please list color and shape:* _____

- Glaucoma
- Glasses/contacts: _____
- Grit or stickiness to the eyes
- Macular degeneration
- Styes
- Bleeding Gums
- Blisters or canker sores
- Gingivitis/gum disease
- Other: _____

Hair, Nail, & Skin Health:

- Brittle or dry hair
- Dandruff
- Hair loss (alopecia)
- Nail fungus (hands or feet)
- Poor nail health or other irregularities
- Acne
- Boils
- Body odor
- Cancers (melanoma, basal, etc)
- Cold sores (herpes simplex)
- Dry skin
- Excessive perspiration
- Hives or rashes
- Itching skin
- Lipomas (fatty tissue growths)
- Moles, recent or changes to
- Oily skin
- Reactions to insect bites
- Scars (locations): _____
- Sebaceous cysts
- Shingles (herpes zoster)
- Skin tags
- Swellings, lumps, nodules
- Warts
- Other: _____

Respiratory Health:

- Allergies/hay fever
- Asthma
- Bronchitis
- Colds, frequent
- Cough (acute or chronic)
- Emphysema
- Hoarseness
- Laryngitis
- Nasal congestion
- Phlegm, excessive production

- Pleurisy
- Pneumonia
- Post-nasal drip
- Shortness of breath
- Snoring
- Sore throat (acute or chronic)
- Other: _____

Blood/Cardiovascular Health:

- Anemia
- Aneurysm
- Angina/heart pain
- Blood clots
- Blood type: A O B AB (*circle*)
- Positive or Negative type (*circle*)
- Bruise easily
- Chest pain or tightness
- Cold hands and feet
- Heart attack (history of)
- Irregular heart beat
- Heart disease
- High cholesterol
- Hypertension (high BP)
- Hypotension (low BP)
- Mitral valve prolapse
- Murmur
- Palpitations
- Stroke (history of)
- Varicose veins
- Other: _____

Gastrointestinal Health:

- Abdominal pain/cramps
- Acid reflux/heartburn
- Anorexia or Bulimia
- Bloating & distension
- Chronic use of laxatives
- Colitis
- Crohn's Disease
- Constipation
- Diarrhea
- Esophageal spasms
- Food allergies/sensitivities
- Gallbladder disease
- Gas/flatulence
- Greasy, fatty food intolerance
- Liver Disease (cirrhosis)
- Liver, fatty
- Hemorrhoids
- Hiccoughs
- Indigestion
- Irritable Bowel Syndrome
- Mouth taste (circle which apply):
bitter; metallic; sticky; sweet
- Nausea and/or vomiting
- Pancreatitis
- Parasites (history of)
- Rectal itching
- Stomach or duodenal ulcers
- Stools (please circle any that apply):
bloody; tarry; clay colored; mucus in
stools; undigested food

Frequency of bowel movements per day:

Do your bowel movements float or sink?

Other: _____

Genito-Urinary Health:

- Bed wetting (or history of)
- Blood in the urine
- Cystitis (bladder pain)
- Dribbling after urination
- Edema/leg swelling
- Frequent urination
- Incontinence
- Kidney disease
- Kidney stones
- Nocturia (night-time urination)
- Nephritis
- Urethritis
- Urinary tract infection history
- How many times a day do you urinate? _____
- What color is your urine? _____
- Other: _____

Women's Reproductive History:

- Age of 1st menses _____
- Length of menses _____
- Time between cycles _____
- Heavy Bleeding
- Light Bleeding
- Menstrual blood color: _____
- Clotting (*please describe the color of the clots*) _____
- Lack of menstruation
- Irregular menstruation
- Painful menstruation
- Pre-menstrual syndrome (breast tenderness, irritability, cramps, etc)
- Bloating, water retention with period
- # of abortions: _____
- # of live births: _____
- # of miscarriages: _____
- Traumatic births
- Use of birth control (*age & duration*) _____
- Postpartum weakness
- Difficult conception/infertility

Women's Health (if applicable):

- Abdominal lumps or masses
- Breast cancer
- Breast cysts or lumps
- Breast tenderness
- Endometriosis
- Estrogen replacement use
- Fibroids
- Hot flashes
- Menopause, age begun
- Menopausal symptoms
- Menstrual odor, strong
- Nipple discharge
- Pelvic/genital pain

- Positive mammogram/pap smear
- Severe menstrual cramps
- Painful sex
- Sex drive low
- Sex drive excessive, difficulty control impulses
- Vaginal discharge
- Vaginal dryness
- Vaginal odor
- Venereal disease
- Yeast infections
- Other: _____

Men's Health (if applicable):

- Erectile dysfunction
- Impotence
- Penile discharge
- Premature ejaculation
- Prostate enlargement/problems
- Seminal incontinence
- Sex drive diminished
- Sex drive excessive
- Venereal disease
- Other: _____

Endocrine Health:

- Addison's disease
- Cushing's syndrome
- Diabetes Type I
- Diabetes Type II
- Diabetes Insipidus
- Fatigue (*time of day*): _____
- Feeling hot or cold (*circle*)
- Hypoglycemia
- Hypothyroid
- Hyperthyroid (Grave's Disease)
- Insulin resistance
- Lethargy
- Pituitary disorders
- Night sweats
- Overweight: How many lbs. overweight? _____
- Weight gain, sudden
- Weight loss
- Other: _____

Neurological & Brain Health:

- Concussion history
- Difficulty concentrating
- Drowsiness
- Epilepsy
- Lack of coordination and balance
- Loss of muscle strength
- Numbness & tingling in the limbs
- Paralysis
- Seizures
- Tremors
- Vertigo or dizziness

Musculo-skeletal Health & Pain:

- Arm and elbow pain
- Hand and wrist pain

- Knee pain
- Leg & calf pain
- Gout
- Hip pain and/or sciatica
- Lower back pain
- Neck, shoulder, upper back pain
- Whole body pain
- Facial pain/paralysis
- Jaw tension/pain (TMJ syndrome)
- Headaches (*location & sensation*): _____

- Migraines
- Rheumatoid arthritis
- Osteo-arthritis
- Osteopenia (weakening bones)
- Osteoporosis (bone loss)
- Sciatica (down back of leg, side of leg, or both?) _____
- Spinal curvature (scoliosis, lordosis, kyphosis, etc) _____
- Tension in the back, shoulders, & neck related to stress response
- Other: _____

Immune Health & Toxicity:

- Candidiasis/ fungal infection
- Chemical sensitivities
- Chemotherapy or radiation treatment currently or history of
- Chronic Fatigue Syndrome
- Chronic infections: _____
- Epstein Barr Virus
- Hepatitis A, B, C, D, E
- HIV/AIDS
- Leukemia
- Lyme disease
- Lymph node swelling
- Lymphoma
- Mononucleosis
- Parasites: _____
- Reactions to food additives
- Recent or past exposure to toxins, chemicals, pesticides, herbicides, mold, etc in the home or workplace
- Live in home older than 30 years

Environmental Adaptation:

- Changes in weather or barometric pressure aggravate symptoms or cause adverse reactions
- Cold/damp environments aggravate symptoms or cause adverse reactions
- Cold/dry environments aggravate symptoms or cause adverse reactions
- Hot/humid environments aggravate symptoms or cause adverse reactions
- Hot/dry environments aggravate symptoms or cause adverse reactions
- Seasonal changes aggravate symptoms or cause adverse reactions

Lifestyle: (*Please indicate amount*)

- Alcohol consumption: _____
- Caffeinated and carbonated beverages: _____
- Coffee or black tea: _____
- Exercise: _____
- Recreational drugs (please list): _____
- Tobacco consumption _____
- Water consumption: _____
- How often do you eat? _____
- Do you suffer from insomnia? _____
- Is it more difficult to get to sleep, stay asleep, or both? _____
- How many hours do you sleep per night? _____
- If you sleep for 8 hours are you rested or still wake tired? _____

Psychological/Emotional Health:

- Anxiety
- Depression
- Worry, over-concern
- Anger, frustration, irritability
- Fear, paranoia
- Grief, sadness
- Bi-polar
- Schizophrenia
- ADD or ADHD
- Addictions. Please list: _____
- Attempted suicide
- Suicidal thoughts
- Panic attacks
- PTSD
- Other: _____

Please list any other areas of concerns:

I certify the above information is true and correct to the best of my knowledge.

Patient Signature:

Date:
