Valley Holistic HEALING | Health Assessment

Thank you for choosing Valley Holistic Healing!

We are delighted to work with you to restore your body's natural rhythm.

The answers you will provide on these forms and the discussions you will share with your practitioner all add up - like individual pieces of a puzzle - to reveal a larger picture of your health and health concerns. This holistic view allows your concerns to be addressed from both a specific *branch* level and also a deeper *root* level.

Please take time to thoughtfully and honestly answer these questionnaires so that the picture of your health and health concerns are revealed as clearly as possible.

Name: ___________________________________ Today's Date: ____________

Address ____

City: _______________________________ State: ________ Zip: _____________

Primary Phone # __________________ Secondary Phone # __________________

E-mail Address ____

Would you like to join Valley Holistic Healing's email list and be the first to know about upcoming health seminars and exclusive specials?

Date of Birth ____________ Age _______ Weight _______ Height______ Sex M / F

Marital Status: ☐ Single ☐ Married or living with significant other
☐ Separated ☐ Divorced ☐ Widowed

Employer ________________________ Occupation ________________________

Emergency Contact _________________________ Phone ___________________

How did you hear about us? ____

Have you ever received acupuncture before? _______________________________

Full payment is due on the day of the appointment.
Receipts for insurance reimbursement will be provided at your request.

We ask for 24 hour advance notice if you need to cancel an appointment.
You may be charged if you cancel an appointment without 24 hours notice.

Patient ID ____________

Rev E 5/09

Valley Holistic HEALING | Medical History

What health concern(s) bring you in today? ________________________________

____

____

____

How do these affect your daily life? ______________________________________

____

____

Have you been examined by a medical doctor for any of these health concerns? Yes / No

If yes, what was the diagnosis? ______________________________________

Do you have other health concerns you wish we could help? _____________________

____

____

List any major surgeries you've had ______________________________________

____

Significant trauma (accidents, falls) ______________________________________

____

Have you ever been diagnosed with any of the following:

☐ Diabetes	☐ High blood pressure	☐ Anemia	☐ Tuberculosis
☐ Seizures	☐ Low blood pressure	☐ Arthritis	☐ Asthma
☐ Blood clots	☐ Substance addiction	☐ Fibromyalgia	☐ Cancer
☐ Stroke	☐ Peripheral neuropathy	☐ Depression	☐ HIV/AIDS
☐ Heart Attack	☐ Ulcer/GI bleeding	☐ Anxiety	☐ Hepatitis

Family medical history (parents, siblings, grandparents) _______________________

____

Past medications (current medications will be listed separately on the risk assessment)

☐ Contraceptives	☐ Pain medication	☐ Anti-hypertensives
☐ Antidepressants	☐ Long-term antibiotics	☐ Cholesterol-lowering drugs
☐ Steroids	☐ Antacids	☐ Other ________________

Valley Holistic HEALING | Health History

Please mark any symptoms you currently have or have had in the past year.

TEMPERATURE
- ☐ Tend to feel hot
- ☐ Tend to feel cold
- ☐ Hot flashes
- ☐ Chills
- ☐ Fever
- ☐ Alternating chills and fever

PERSPIRATION/THIRST
- ☐ Sweat with little exertion
- ☐ Night sweats
- ☐ Can't sweat
- ☐ Thirsty and drink cold
- ☐ Thirsty and drink hot
- ☐ Thirsty but don't drink
- ☐ Not thirsty

ENERGY
- ☐ High energy/nervous
- ☐ Good energy
- ☐ Okay energy/slightly low
- ☐ Low energy/fatigue

HEAD
- ☐ Headaches
- ☐ Migraines
- ☐ Dizzy/lightheaded
- ☐ Fainting
- ☐ Foggy-headedness
- ☐ Seizures
- ☐ Tremors
- ☐ Sinus congestion
- ☐ Nasal discharge

SENSES
- ☐ Declining vision
- ☐ Eyes sensitive to light
- ☐ Red/itchy eyes
- ☐ Floating spots in vision
- ☐ Poor hearing
- ☐ Ear ringing
- ☐ Poor sense of smell
- ☐ Earaches
- ☐ Decreased night vision

MOUTH
- ☐ Frequent sore throats
- ☐ Poor teeth
- ☐ Mouth/canker sores
- ☐ Lip sores
- ☐ Dry/chapped lips
- ☐ Dry mouth and throat
- ☐ Lump in the throat
- ☐ Swollen/painful gums
- ☐ Taste in mouth, describe ____________

SKIN, HAIR & NAILS
- ☐ Thin skin/nails
- ☐ Dry skin/nails
- ☐ Easily bruised
- ☐ Dark under eyes
- ☐ Lumps
- ☐ Acne
- ☐ Abscesses/infection
- ☐ Prematurely gray hair
- ☐ Hair loss
- ☐ Dry/brittle hair

LUNGS & HEART
- ☐ Wheezing
- ☐ Coughing
- ☐ Short of breath
- ☐ Tight sensation in chest
- ☐ Frequent colds, >2/year
- ☐ Seasonal allergies
- ☐ Slow heart rate
- ☐ Fast heart rate
- ☐ Irregular heart rhythm
- ☐ Palpitations/fluttering sensation
- ☐ Chest pain
- ☐ High blood pressure
- ☐ Low blood pressure

APPETITE & DIGESTION
- ☐ Excessive appetite
- ☐ Poor appetite
- ☐ Excessive saliva
- ☐ Heartburn/reflux
- ☐ Nausea/vomiting
- ☐ Gas
- ☐ Tired after eating
- ☐ Bad breath
- ☐ Bloating/distention
- ☐ Abdominal pain
- ☐ Stomach pain
- ☐ Belching/hiccups
- ☐ Gall stones
- ☐ Pain under ribs

Patient ID ____________

CRAVINGS
- ☐ Sweet
- ☐ Salty
- ☐ Sour
- ☐ Bitter
- ☐ Hot/spicy
- ☐ Strong flavor/pungent
- ☐ Bland
- ☐ Crunchy
- ☐ Other ___________

BOWEL MOVEMENTS
- ☐ Constipation
- ☐ Loose stool/diarrhea
- ☐ Alternating constipation and diarrhea
- ☐ Cramps with BM
- ☐ Incomplete BM
- ☐ Burning with BM
- ☐ Hemorrhoids
- ☐ Bowel incontinence
- ☐ Blood or mucus in stool
- ☐ Foul odor

URINATION
- ☐ Dark urine
- ☐ Cloudy urine
- ☐ Burning urination
- ☐ Scanty urine
- ☐ Profuse urine
- ☐ Decreased bladder control
- ☐ Frequent urination
- ☐ Wake at night twice or more to urinate
- ☐ Frequent UTIs
- ☐ Kidney stones

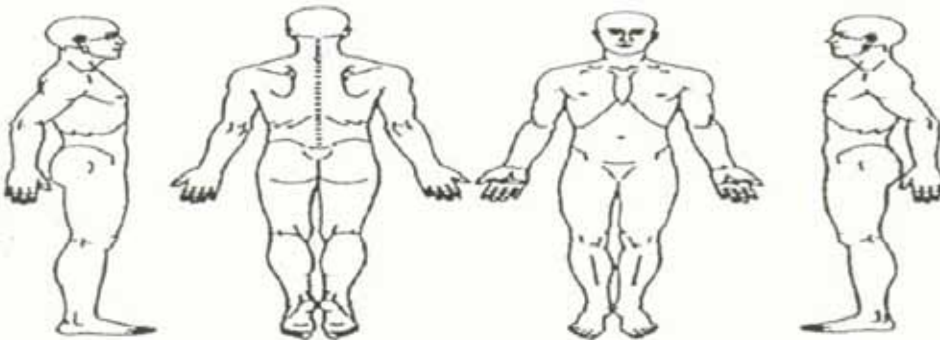
SLEEP
- ☐ Insomnia
- ☐ Excessive sleep
- ☐ Difficulty falling asleep
- ☐ Wake during the night
- ☐ Lots of vivid dreams
- ☐ Disturbing dreams
- ☐ Don't get enough sleep
- ☐ Wake unrefreshed

Number of hours of sleep each night ________

MENTAL & EMOTIONAL
- ☐ Forgetful/poor memory
- ☐ Poor concentration
- ☐ Irritable/angry
- ☐ Sad
- ☐ Tearful/weepy
- ☐ Restless
- ☐ Anxious/worried
- ☐ Can't stop thinking
- ☐ Fearful/easily startled
- ☐ Manic
- ☐ Depressed
- ☐ Frequent sighing or yawning

DIET & LIFESTYLE
- ☐ Poor diet
- ☐ Consume caffeine daily
- ☐ Smoke cigarettes
- ☐ Chew tobacco
- ☐ Drink alcohol
- ☐ Use drugs
- ☐ Too little activity/ exercise
- ☐ Exercise excessively
- ☐ Eating disorder
- ☐ Job stress/concerns
- ☐ Family stress/concerns
- ☐ Other stress/concerns

MUSCULOSKELETAL & EXTREMITIES
Mark any areas where you experience pain or numbness



- ☐ TMJ
- ☐ Scoliosis
- ☐ Joint swelling
- ☐ All over body pain
- ☐ Muscle tightness
- ☐ Cold back or knees
- ☐ Weak back or knees
- ☐ Body heaviness

Valley Holistic HEALING | Women's Health History

GENERAL GYNECOLOGY

☐ High sexual energy
☐ Low sexual energy
☐ Chronic vaginal discharge
☐ Regular yeast infections
☐ Vaginal dryness
☐ Breast lumps/nodules
☐ Mastitis
☐ Cysts
☐ Endometriosis
☐ Pelvic abnormalities/adhesions
☐ Fibroids
☐ PID
☐ STDs
☐ Abnormal pap smear
☐ Uterine or bladder prolapse
☐ Others ___________________________

REPRODUCTIVE HISTORY

Are you currently using birth control? Y / N
Are you trying to conceive? Y / N
Are you currently lactating? Y / N
How many pregnancies have you had? ____
How many children do you have? ____
How many abortions have you had? ____
How many miscarriages have you had? ____

Have you had any:
☐ High-risk pregnancies
☐ Difficult labor/deliveries
☐ Postpartum concerns
☐ Lactation concerns

MENOPAUSE

☐ Peri-menopausal
☐ Post-menopause since _____________
(Please answer menstruation questions to the best of your recollection)

MENSTRUATION

Age when menses began ________
Menstruation lasts ______ days
☐ Regular cycle: _____ days total
☐ Irregular: ______ to ______ days
Can you tell when you ovulate? Y / N

During your period, the flow is:
☐ Light/spotting on days ________
☐ Medium on days ________
☐ Heavy on days ________
☐ With clots on days ________
☐ Spotting between periods

What color is the blood?
☐ Light Red on days ______
☐ Bright Red on days ________
☐ Dark Red on days ________
☐ Purple on days ________
☐ Brown on days ________
☐ Black on days ________

PMS

☐ Acne
☐ Cramps/Backache
☐ Bowel changes
☐ Breast changes
☐ Food cravings
☐ Irritability/anger
☐ Nausea
☐ Sad/Weeping
☐ Others _________________

POST-MENSTRUATION

☐ Dizziness
☐ Fatigue
☐ Insomnia
☐ Night sweats
☐ Others _________________

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Patient ID ______________