WILDSONG
WELLNESS
Acupuncture. Herbal Medicine.

Health History

Name | Today's Date

Address | City | State | Zip

Phone (home) | (cell)

Email | Marital/Relationship status

Date of Birth | Age | Gender: ☐ M ☐ F | Height | Weight

Emergency Contact | Phone

Primary physician | Phone

Occupation | Employer

How did you hear about our clinic?

Please list your major health concerns in order of importance:

Complaint	Since (mo/yr)	Severity (1-10, 10=severe)	Other treatment (MD, DC, DO)

Health History continued

How does each complaint above interfere with your daily living (i.e. sleep, activities):

What makes each complaint above better (i.e. heat, cold, rest):

What makes each complaint above worse (i.e. heat, cold, rest):

Have you ever been diagnosed with any of the following:

- ☐ Diabetes
- ☐ Arthritis
- ☐ Depression
- ☐ Anxiety
- ☐ MRSA
- ☐ High blood pressure
- ☐ Heart attack
- ☐ HIV/AIDS
- ☐ Ulcer/GI bleeding
- ☐ C-dif
- ☐ Anemia
- ☐ Cancer
- ☐ Hepatitis
- ☐ Asthma
- ☐ Bleeding disorder
- ☐ Hyper/hypo Thyroid
- ☐ Stroke
- ☐ Autoimmune disorder (Fibromyalgia, MS, Lyme)

Please list any prescriptions or over-the-counter medications or supplements you are currently taking:

Medication/supplement	Reason	Dosage	How long?

Please list all hospitalizations, surgeries, and traumas:

When	Reason

Please list all known food or drug allergies:

Health History continued

Family medical history (parents, siblings, grandparents):

What are your short-term wellness goals?

What are your long-term wellness goals?

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

HEAD/EARS/EYES/MOUTH

- ☐ Poor sense of smell
- ☐ Sinus congestion, infection
- ☐ Nasal discharge
- ☐ Nosebleeds
- ☐ Dry, red, or itchy eyes
- ☐ Blurred vision
- ☐ Decreased night vision
- ☐ Sensitive to light
- ☐ Floating spots in vision
- ☐ Cataracts
- ☐ Poor or decreased hearing
- ☐ Ear ringing
- ☐ Ear aches
- ☐ Dizzy/lightheaded
- ☐ Fainting
- ☐ Seizures
- ☐ Tremors
- ☐ Headaches/Migraines
  - Location _____
  - Frequency_____
  - Duration _____
  - Pain Quality _____
  - (sharp, dull, stabbing)
- ☐ Frequent sore throats
- ☐ Mouth/canker sores
- ☐ Lip sores
- ☐ Dry, chapped lips
- ☐ Dry mouth, throat
- ☐ Difficulty swallowing
- ☐ Swollen, painful, bleeding gums
- ☐ Grinding teeth
- ☐ Poor teeth
- ☐ Weak, hoarse voice

TEMP/SWEATING

- ☐ Tend to feel hot
- ☐ Tend to feel cold
- ☐ Hot flashes
- ☐ Chills
- ☐ Fever
- ☐ Alternating chills & fever
- ☐ Sweat with little exertion
- ☐ Night sweats
- ☐ Can't sweat

CHEST & ABDOMEN

- ☐ Wheezing
- ☐ Coughing
- ☐ Shortness of breath
- ☐ Tight sensation in chest
- ☐ Frequent colds, >2/yr
- ☐ Seasonal allergies
- ☐ Palpitations
- ☐ Chest pain
- ☐ Stomach pain/pressure
- ☐ Bloating
- ☐ Abdomen pain/pressure
- ☐ Ribside pain

SKIN, HAIR, & NAILS

- ☐ Dry skin, nails
- ☐ Oily skin
- ☐ Dry hair
- ☐ Oily hair
- ☐ Acne
- ☐ Rashes, hives, itching
- ☐ Sores that won't heal
- ☐ Easily bruised
- ☐ Prematurely grey hair
- ☐ Hair loss

Health History continued

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

APPETITE/DIGESTION

- ☐ Excessive appetite
- ☐ Poor appetite
- ☐ Bad breath
- ☐ Heartburn/reflux
- ☐ Belching/hiccups
- ☐ Nausea/vomiting
- ☐ Thirsty & drink cold
- ☐ Thirsty & drink hot
- ☐ Thirsty but don't drink
- ☐ Not thirsty
- ☐ Gas
- ☐ Gall stones
- ☐ Food sensitivities
- ☐ Crave salt
- ☐ Crave sugar
- ☐ Weight gain ____ lbs
- ☐ Weight loss ____ lbs
- ☐ Consume caffeine
- ☐ Smoke cigarettes
- ☐ Chew tobacco
- ☐ Drink alcohol
- ☐ Use drugs
- ☐ Too little activity/exercise
- ☐ Exercise excessively
- ☐ Eating disorder

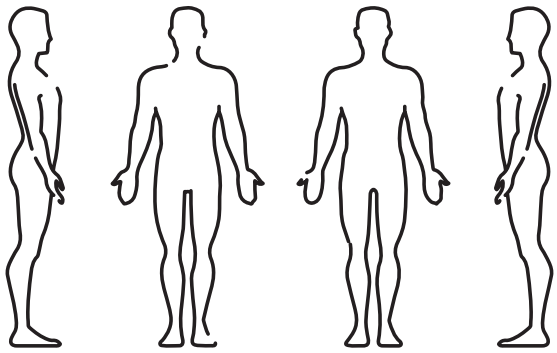
URINATION & BOWEL MOVEMENTS

- ☐ Dark urine
- ☐ Pale urine
- ☐ Cloudy urine
- ☐ Scanty urine
- ☐ Profuse urine
- ☐ Blood in urine
- ☐ Burning urination
- ☐ Painful urination
- ☐ Frequent urination
- ☐ Frequent UTIs
- ☐ Kidney stones
- ☐ Urinary urgency/incontinence
- ☐ Dribbling urine
- ☐ Weak urine stream
- ☐ Difficulty emptying bladder
- ☐ Constipation
- ☐ Loose stool/diarrhea
- ☐ Alternating diarrhea, constipation
- ☐ Cramps with BM
- ☐ Incomplete BM
- ☐ Burning with BM
- ☐ Blood, mucus in stool
- ☐ Foul odor
- ☐ Sticky stool

MUSCULOSKELETAL & EXTREMITIES

- ☐ TMJ
- ☐ Muscle spasm
- ☐ All over body pain
- ☐ Muscle tightness
- ☐ Joint swelling, pain
- ☐ Weak back or knees
- ☐ Body heaviness
- ☐ Cold back or knees
- ☐ Tremors
- ☐ Numbness/tingling

Mark any areas where you experience pain or numbness:



SLEEP

- ☐ Insomnia
- ☐ Excessive sleep
- ☐ Difficulty falling asleep
- ☐ Difficulty staying asleep
- ☐ Vivid dreams
- ☐ Wake unrefreshed

ENERGY

- ☐ High energy/nervous
- ☐ Good energy
- ☐ OK energy/slightly low
- ☐ Low energy/fatigue
- ☐ Energy drops (time of day)

  _____ am / pm

MENTAL/EMOTIONAL

- ☐ Forgetful/poor memory
- ☐ Trouble focusing
- ☐ Irritable/angry
- ☐ Sad/weepy
- ☐ Anxious/worry
- ☐ Mind racing
- ☐ Fearful, easily frightened
- ☐ Easily stressed
- ☐ Job stress/concerns
- ☐ Family stress/concerns
- ☐ Other stress/concerns

Health History continued

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

SEXUAL HEALTH

- ☐ High sexual energy
- ☐ Low sexual energy
- ☐ Genital pain/itching
- ☐ Genital lesions/discharge
- ☐ Painful intercourse
- ☐ Infertility
- ☐ Chronic yeast infection
- ☐ Vaginal dryness
- ☐ Fibroids, cysts
- ☐ Breast lumps/nodules
- ☐ Endometriosis
- ☐ Abnormal pap smears
- ☐ PCOS
- ☐ STDs
- ☐ Erectile dysfunction
- ☐ Premature ejaculation
- ☐ Nocturnal emission
- ☐ Enlarged prostrate
- ☐ Painful, swollen testicles

PMS

- ☐ Acne
- ☐ Cramps before/during period
- ☐ Cramps after/during period
- ☐ Breast changes
- ☐ Bowel changes
- ☐ Bloating
- ☐ Food cravings
- ☐ Irritability/anger
- ☐ Sad/weeping

MENSTRUATION

Age when menses began _____

Menstruation lasts ____ days

Regular cycle: ____ days total

Irregular cycle: ____ to ____ days

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 _____

REPRODUCTIVE HISTORY

Are you currently pregnant?

☐ Yes ☐ No

Are you currently using birth control?

☐ Yes ☐ No

Are you trying to conceive?

☐ Yes ☐ No

Are you currently lactating?

☐ Yes ☐ No

How many pregnancies have you had?

_____

How many children do you have?

_____

How many abortions have you had?

_____

How many miscarriages have you had?

_____

POST-MENSTRUATION

- ☐ Dizziness
- ☐ Fatigue
- ☐ Insomnia
- ☐ Night sweats
- ☐ Other _____

MENOPAUSE

- ☐ Peri-menopausal
- ☐ Post-menopause since _____