Heartland Oriental Medicine, LLC

215 South Maize Road, Suite 103, Wichita, KS 67209
(316) 512-5585

Confidential Patient Health History (Please circle appropriate answers)

Name (first, middle initial, last): _____ DOB(mm-dd-yyyy):: ____ - ____ - ____

Marital Status: S M D W Gender: M F Height: ____ ft ____ in Weight: ____ lb.

Address: _____ City: _____ State: ____ Zip: _____

Phone: Home: _____ Cell: _____ e-mail: _____

Occupation: _____ Employer: _____

Employer Address: _____ Employer Phone: _____

Parent or Guardian (if minor): _____ Phone: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

Family physician: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Referred by: _____ Address: _____

Have you ever had acupuncture before? ___ Y ___ N Have you ever had Chinese herbal medicine? Y N

Main reason(s) for today's visit: _____

How long have you had this condition? ____ Years ____ Months ____ Weeks ____ Days

To what extent does this condition interfere with your daily activities? ____ Work ____ Sleep ____ Home life

What makes the condition better? _____

What makes the condition worse? _____

Have you been given a diagnosis for this condition? If so, please state. _____

What type(s) of treatment(s) have you tried?

Are you under the care of a physician now? Y N If yes, for what reason? _____

Physician's Name: _____ Physician's phone: _____

If you want me to discuss your case with your physician, sign here to give consent: _____

Other current therapies:

Past Medical History:

AIDS/HIV	Alcoholism	Allergies	Appendicitis	Arteriosclerosis
Asthma	Birth Trauma	Cancer	Chicken Pox	Diabetes
Emphysema	Epilepsy	Goiter	Gout	Heart Disease
Hepatitis	Herpes	High Blood Pressure	Measles	Migraines
Multiple Sclerosis	Mumps	Pacemaker	Pleurisy	Pneumonia
Polio	Rheumatic Fever	Scarlet Fever	Seizures	Stroke
Thyroid Disorders	Tuberculosis	Typhoid Fever	Ulcers	Venereal Disease
Whooping Cough	Other: _____			

Medicines taken within the last two months (vitamins, drugs, herbs, etc.): _____

Surgery (please list): _____

Major Trauma (car, falls, emotional, etc., please list): _____

Significant Dental Work (type and date): _____

Your Diet:

Have you been on a restricted diet? Y N If yes, please describe: _____

Please describe your average daily diet: Appetite: High Low Snacks: Y N If yes, what kind? _____

No. of cups of coffee, tea or cola:: times/day times/week Diet sodas glasses/cans per day/per week

Thirsty for water: Y N ____ glasses/day Sugar/sweetener intake: Sugar Artificial sweetener Preferred salty foods

Vegetarian/vegan Dairy products Type of Meat: Fish/shell fish Chicken Beef Pork Lamb/wild game

Other: _____

Your Lifestyle:

Occupational Stress (chemical, physical, psychological, etc.): _____

Do you have a regular exercise program? Y N If yes, please describe: _____

Alcohol consumed per week: Don't drink Beer Wine Hard liquor Amount consumed: _____

Tobacco use: _____ Cigarettes/week _____ Cans of chewing tobacco/week Other: _____

Recreational drug use: _____

Other health issues you would like to discuss:

Please rate the degree of severity of your problem now (0 is no problem, 10 is worst imaginable):

0 1 2 3 4 5 6 7 8 9 10

Please rate the greatest degree of severity of your problem within the last week:

0 1 2 3 4 5 6 7 8 9 10

Please mark the areas on the body where you area having symptoms.

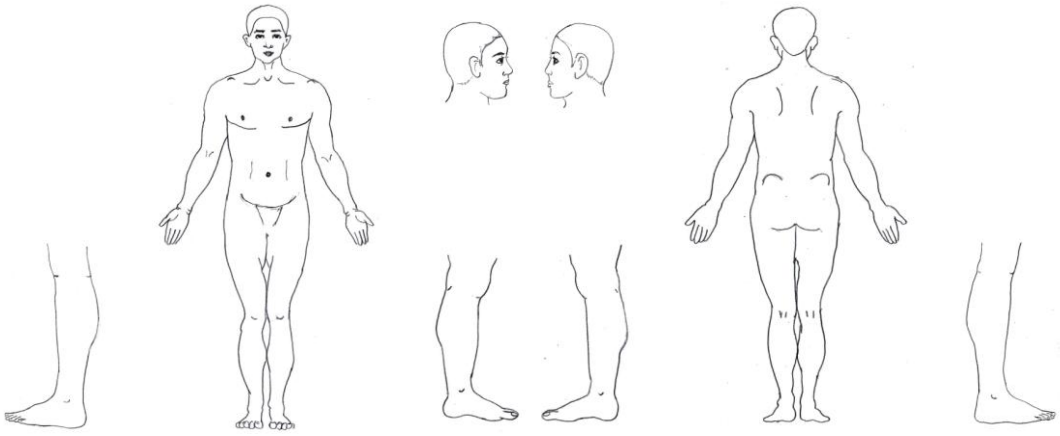
B = Burning

N = Numbness/Tingling

P = Pain

R = Radiating

T = Tenderness



Please rate the pain level:

0 1 2 3 4 5 6 7 8 9 10

Minimal Excruciating

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Chill Fever:
Normal
Always hot Esp. in the morning in the afternoon In the evening
Always cold Esp. in the morning in the afternoon In the evening
Hot flashes: Yes No If 'Yes' During the day In the evening:

Thirst Cravings:
Normal Not Thirsty Always Thirsty
When thirsty, what temperature beverages do you prefer: Room temp Hot Cold
Cravings for: Sweet Sour Salty Spicy Greasy/fried Foods
If there is any taste in the mouth, it will taste Bitter Sweet Sour Metallic

Sweating:
Only upon exertion Hardly sweat Sweating all the time Esp. in the a.m. p.m.

Sleep*:*
Normal easy to go to sleep Hard to go to sleep Tossing & turning
During the sleep, are you: easily awaken Due to _____ Sleep very deeply
If your sleep is disturbed by frequent urination, how often: _____ x/night

Diet Appetite*:*
normal always hungry esp. in the morning afternoon evening no appetite
Fatigue after a meal? Yes No
Which is your biggest meal? Breakfast Lunch Dinner

Bowel Movement*:*
Frequency: ___ x every ___ day(s) Often constipated Often have diarrhea IBS
Color of the stool: Brown Black Other: _____
Any undigested food in the stool? Yes No

Urination*:*
Please circle one: Input = output Input > output Input < output
Do you have: Frequent urination Dribbling Incontinence
Color of the urine: clear light yellow yellow dark yellow other:

Menstruation *(for female patients ONLY)* Date last menses: _____ heavy/light lasted ___days
Menopausal _____ # of pregnancy(ies): ___ live ___ miscarriage If you had an hysterectomy, date of surgery: _____

Emotion: normal happy anxious stressed depressed due to: home work other
If 'other' please explain: _____

Energy Level: Tired all the time L 1 2 3 4 5 H Energetic all the time

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What are your concerns about your health? Please list in the order of importance:

1

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