

# SNOW BLOSSOM ACUPUNCTURE

907-245-7669 615 E. 82<sup>nd</sup> Ave, Suite 302 Anchorage, AK 99518  
Seth Wood, LAc. ~ Kristen Taylor, LAc., LMT

## PATIENT HEALTH HISTORY

Date: \_\_\_\_\_

Name: \_\_\_\_\_  
(First) (Middle) (Last)

DOB: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_ Marital Status: S M D W

Address: \_\_\_\_\_ City/State: \_\_\_\_\_ ZIP: \_\_\_\_\_

Telephone: \_\_\_\_\_ E-Mail: \_\_\_\_\_

Emergency Contact (name, telephone, relation): \_\_\_\_\_  
\_\_\_\_\_

Current Physician: \_\_\_\_\_ Telephone: \_\_\_\_\_

Most Recent Healthcare Treatment (when, what, where): \_\_\_\_\_  
\_\_\_\_\_

Please identify the health concerns that have brought you into Snow Blossom Acupuncture (in order of importance):

- | <u>Condition</u>  | <u>Past Treatment</u> |
|---|-----------------------|
| 1. _____<br>How does this condition affect your life? _____ | _____                 |
| 2. _____<br>How does this condition affect your life? _____ | _____                 |
| 3. _____<br>How does this condition affect your life? _____ | _____                 |
| 4. _____<br>How does this condition affect your life? _____ | _____                 |

Please list any **foods, medications, or drugs** you are hypersensitive or allergic to (including reactions):  
\_\_\_\_\_  
\_\_\_\_\_

Please list any **medications, vitamins or supplements** you are currently taking (including dosages):  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Do you have any reason to believe you may be **pregnant**? Y / N  
If yes, how far along are you? \_\_\_\_\_

Do you have any **infectious diseases**? Y / N If yes, please identify: \_\_\_\_\_

**Height:** \_\_\_\_\_ **Weight** (Current): \_\_\_\_\_ Past Maximum: \_\_\_\_\_ When? \_\_\_\_\_

**Blood Pressure:** What was your most recent reading? \_\_\_\_/\_\_\_\_ When was this taken? \_\_\_\_\_

**Childhood Illness:** (please circle any that you have had)

Scarlet Fever Diphtheria Rheumatic Fever Measles German Measles Chicken Pox

**Immunizations:** (please circle any that you have had)

Polio Tetanus Measles/Mumps/Rubella Pertussis Diphtheria Hepatitis A & B Other: \_\_\_\_\_

**Hospitalizations and Surgeries:**

<u>Reason</u>	<u>When</u>	<u>Reason</u>	<u>When</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**X-Rays, CT Scans, MRI's, NMR's, Other Special Studies** (please circle or name study):

<u>Test/Reason</u>	<u>When</u>	<u>Test/Reason</u>	<u>When</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**Family History:** Father Mother Brothers Sisters Spouse Grandparents  
(check those applicable)

Age (if living)	_____	_____	_____	_____	_____	_____
Health (G=good, P=poor)	_____	_____	_____	_____	_____	_____
Cancer	_____	_____	_____	_____	_____	_____
Diabetes	_____	_____	_____	_____	_____	_____
Heart Disease	_____	_____	_____	_____	_____	_____
High Blood Pressure	_____	_____	_____	_____	_____	_____
Stroke	_____	_____	_____	_____	_____	_____
Mental Illness	_____	_____	_____	_____	_____	_____
Asthma/Hay Fever	_____	_____	_____	_____	_____	_____
Kidney Disease	_____	_____	_____	_____	_____	_____
Age at death	_____	_____	_____	_____	_____	_____
Cause of death	_____	_____	_____	_____	_____	_____

For the conditions listed below, please **CHECK** next to any that you have now and **UNDERLINE** any you have experienced in the past:

**Emotional**

Mood Swings  
Nervousness  
Mental Tension

**Energy & Immunity**

Fatigue  
Slow Wound Healing  
Chronic Infections  
Chronic Fatigue Syndrome

**Head, Eye, Ear, Nose, &**

**Throat**

Impaired Vision  
Eye Pain/Strain  
Glaucoma  
Glasses/Contacts  
Tearing/Dryness  
Impaired Hearing  
Ear Ringing  
Ear Aches  
Headaches  
Sinus Problems  
Nose Bleeds  
Frequent Sore Throats  
Teeth Grinding  
TMJ  
Hay Fever

**Cardiovascular**

Heart Disease  
Chest Pain  
Swelling of Ankles  
High Blood Pressure  
Palpitations/Fluttering  
Stroke  
Heart Murmurs  
Rheumatic Fever  
Varicose Veins

**Gastrointestinal**

Ulcers  
Changes in Appetite  
Nausea/Vomiting  
Epigastric Pain  
Passing Gas  
Heartburn  
Belching  
Gall Bladder Disease  
Liver Disease  
Hepatitis B or C  
Hemorrhoids  
Abdominal Pain

**Genito-Urinary Tract**

Kidney Disease  
Painful Urination  
Frequent UTI  
Frequent Urination  
Kidney Stones  
Impaired Urination  
Blood in Urine  
Frequent Urination at  
Night

**Female Reproductive/**

**Breasts**

Irregular Cycles  
Breast Lumps/Tenderness  
Nipple Discharge  
Heavy Flow  
Vaginal Discharge  
Premenstrual Problems  
Clotting  
Bleeding Between Cycles  
Menopausal Symptoms  
Difficulty Conceiving  
Painful Periods

**Male Reproductive**

Sexual Difficulties  
Prostate Problems  
Testicular Pain/Swelling  
Penile Discharge

**Musculoskeletal**

Neck/Shoulder Pain  
Muscle Spasms/Cramps  
Arm Pain  
Upper Back Pain  
Mid Back Pain  
Low Back Pain  
Leg Pain  
Joint Pain (if so, where?):  
\_\_\_\_\_  
\_\_\_\_\_

**Neurological**

Vertigo/Dizziness  
Paralysis  
Numbness/Tingling  
Loss of Balance  
Seizures/Epilepsy

**Endocrine**

Hypothyroid  
Hypoglycemia  
Hyperthyroid  
Diabetes Mellitus  
Night Sweats  
Feeling Hot or Cold

**Other**

Anemia  
Cancer  
Rashes  
Eczema/Hives  
Cold Hands/Feet

**Menstrual/Birthing History:**

- a. Age of First Menses: \_\_\_\_\_
- b. Number of Days of Flow: \_\_\_\_\_
- c. Length of Cycle: \_\_\_\_\_
- d. Birth Control Type: \_\_\_\_\_
- e. Number of Pregnancies: \_\_\_\_\_
- f. Number of Miscarriages: \_\_\_\_\_
- g. Number of Abortions: \_\_\_\_\_
- h. Number of Live Births: \_\_\_\_\_

Is there anything else we should know? \_\_\_\_\_  
\_\_\_\_\_

**Lifestyle:**

- a. Do you typically eat three meals per day? Y / N If no, how many? \_\_\_\_\_
- b. Do you feel you have a healthy diet? Y / N
- c. Do you have particular food cravings? \_\_\_\_\_
- d. Exercise routine: \_\_\_\_\_
- e. Spiritual practice: \_\_\_\_\_
- f. On average, how many hours per night do you sleep? \_\_\_\_\_ Do you wake rested? \_\_\_\_\_
- g. Occupation: \_\_\_\_\_  
Employer: \_\_\_\_\_  
Hours per week: \_\_\_\_\_
- h. Nicotine/Alcohol/Caffeine use: \_\_\_\_\_  
\_\_\_\_\_
- i. Have you experienced any major traumas? Y / N Explain: \_\_\_\_\_  
\_\_\_\_\_
- j. How many glasses of non-caffeinated, non-carbonated beverages do you drink per day? \_\_\_\_\_
- k. Television habits: \_\_\_\_\_ Reading habits: \_\_\_\_\_
- l. Interests and hobbies: \_\_\_\_\_  
\_\_\_\_\_

***How did you hear about us?***

***Would you like to be on our E-mail list?***