Watershed Wellness, LLC.
Patient Health History

DOB ____/____/____ Age: _____

Name:_____Date:_____
(First) (Middle) (Last)

Street Address:_____

City:_____ State:_____ Zip Code: _____

Mailing Address (if different):_____

Home Tel. No:_____Work Tel No:_____Cell:_____

Email:_____ Social Security:_____-_____-_____

Gender:_____ Marital Status:_____ Live with: Spouse ____ Children ____ Partner ____ Friend ____ Alone ____

Emergency Contact:_____ Telephone:_____ Relationship: _____

Do you have pets? Yes ___ No ___ If yes, what type: _____

How did you hear about us? (We acknowledge and reward referrals)

_____

_____

Successful health care and preventative medicine are only possible when the physician has a complete understanding of the patient physically, mentally and emotionally. Please complete this questionnaire as thoroughly as possible. Please print legibly and indicate areas that are confusing to you with a question mark. Thank you.

Have you had acupuncture before? If yes, what was your experience? _____

_____.

1. Are you currently receiving health care? Yes No If yes, where and from whom? _____

_____.

2. Please identify the health concerns that have brought you to Watershed Wellness below. Please list in order of importance.

Condition **Past Treatment**

A. _____ _____

How does this condition affect you? _____

B. _____ _____

How does this condition affect you? _____

Condition **Past Treatment**

C. _____ _____

How does this condition affect you? _____

D. _____ _____

How does this condition affect you? _____

3. Do you have any reason to believe that you are pregnant? Yes No

4. Do you have any chronic infectious diseases? Yes No If yes, please explain: _____

_____.

5. Are you currently suffering from any chronic illness? Yes No If yes, please explain: _____

_____.

6. If applicable, list any foods, drugs or medications you are hypersensitive or allergic to. Please include the type of reaction: _____.

7. Please circle any of the following medication that you are currently taking:

Laxatives	Pain Relievers	Antacids	Thyroid Medication	Appetite Suppressants
Antibiotics	Tranquilizers	Sleeping Pills	Cortisone	Blood Pressure Medication

8. Please list any prescription medications, over-the-counter medications, vitamins and supplements that you are currently taking:

1. _____ 3. _____

2. _____ 4. _____

9. **Height**: _____ **Current Weight**: _____ Past Maximum Weight: _____ When? _____

10. Blood Pressure: What was your most recent blood pressure reading? _____/_____ When was this reading taken? _____.

11. **Childhood or Adult Illnesses** (please circle any that apply to you):

Scarlet Fever	Diphtheria	Rheumatic Fever	Mumps	Measles
German Measles	Streptococcus	Staphylococcus	Chicken Pox	MRSA

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

Polio	Tetanus	Pertussis	Diphtheria
Measles/Mumps/Rubella	Other: _____		

13. **Hospitalizations and Surgeries:**

Reason	When	Reason	When
_____	_____	_____	_____
_____	_____	_____	_____

14. **X-Rays/CAT Scans/MRI's/NMR's/Special Studies:**

Reason	When	Reason	When
_____	_____	_____	_____
_____	_____	_____	_____

15. **Family History:**

	Mother	Father	Brothers	Sisters	Spouse	Children
Age, if living:						
Health (G=good, P=poor):						
Age at death (if deceased):						
Cause of death:						

Check any conditions that apply to members of your family:

	Mother	Father	Brothers	Sisters	Spouse	Children
Cancer:						
Diabetes:						
Heart Disease:						
High Blood Pressure:						
Stroke:						
Mental Illness:						

16. **Emotional** (please circle any that you experience now and underline any that you have experienced in the past):

Mood Swings Nervousness Anxiety Mental Tension

17. **Energy and Immunity** (please circle any that you experience now and underline any that you have experienced in the past):

Frequent Common Cold Slow Wound Healing Chronic Infections Fatigue

Chronic Fatigue Syndrome

18. **Head, Eye, Ear, Nose and Throat** (please circle any that you experience now and underline any that you have experienced in the past):

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

19. **Respiratory** (please circle any that you experience now and underline any that you have experienced in the past):

Pneumonia	Frequent Common Colds	Difficulty Breathing	Emphysema
Persistent Cough	Pleurisy	Asthma	Tuberculosis
Shortness of Breath	Other Respiratory Problems: _____		

20. **Cardiovascular** (please circle any that you experience now and underline any that you have experienced in the past):

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

21. **Gastrointestinal** (please circle any that you experience now and underline any that you have experienced in the past):

Ulcers	Changes in Appetite	Nausea/Vomiting	Epigastric Pain
Passing Gas	Heartburn	Belching	Gall Bladder Disease
Liver Disease	Hepatitis B or C	Hemorrhoids	Abdominal Pain
Stool:	Diarrhea	Constipation	Undigested Food
Mucous in Stool	Blood in Stool		

22. **Genito-Urinary Tract** (please circle any that you experience now and underline any that you have experienced in the past):

Kidney Disease	Painful Urination	Frequent Urination	Venereal Disease
Kidney Stones	Impaired Urination	Frequent Urination at Night	
Frequent Urinary Tract Infections			

23. **Female Reproductive/Breasts** (please circle any that you experience now and underline any that you have experienced in the past):

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

24. **Menstrual/Birthing History:**

A. Age of First Menses: _____	D. # of Pregnancies: _____	G. # of Abortions: _____
B. # of Days of Menses: _____	E. # of Miscarriages: _____	H. # of Live Births
C. Length of Cycle: _____	F. Birth Control: _____	

25. **Male Reproductive** (please circle any that you experience now and underline any that you have experienced in the past):

Sexual Difficulties	Prostate Problems	Testicular Pain/Swelling	Penile Discharge

26. **Musculoskeletal** (please circle any that you experience now and underline any that you have experienced in the past):

Neck/Shoulder Pain	Muscle Spasms/Cramps	Arm Pain	Upper Back Pain
Mid Back Pain	Low Back Pain	Leg Pain	

Joint Pain (if so, where?): _____

27. **Neurologic** (please circle any that you experience now and underline any that you have experienced in the past):

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

28. **Endocrine** (please circle any that you experience now and underline any that you have experienced in the past):

Hypothyroid	Hyperthyroid	Hypoglycemia	Diabetes Mellitus
Night Sweats	Feeling Hot or Cold		

29. **Skin** (please circle any that you experience now and underline any that you have experienced in the past):

Rashes	Eczema/Hives	Psoriasis

30. **Other** (please circle any that you experience now and underline any that you have experienced in the past):

Anemia	Cancer	Cold Hands/Feet

Do you have any chronic infectious diseases? _____

Is there anything else we should know? _____

_____

_____

31. **Lifestyle:**

A. Please indicate typical food intake:

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

B. Daily Exercise: _____

C. Sleep Habits: _____

E. Occupation: _____ Employer: _____ Hours/Week: _____

Do you enjoy work? Yes No Why/Why not? _____

F. Nicotine/Alcohol/Caffeine Use: _____

G. Have you experienced any major traumas? Yes No Explain: _____

_____

H. Daily Consumption of Liquids: _____

I. Television Habits: _____

J. Reading Habits: _____

K. Interests and Hobbies: _____