Jenny Johnston, L.Ac., Dipl.O.M.

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Patient Information

Date_________________ Name____

Address_______________________________________City State Zip____________________________

Home Phone__________________________________Work Phone_______________________________

Other/Cell Phone_____________________________Email_____________________________________

(Email is only used for appointment confirmations unless otherwise specified)

Preferred form of communication? Email or Phone May we leave a message? Y/N

Would you like to receive our monthly educational newsletter via email? Yes or No

(We will not share your email address with others)

Age_____________Birthdate__________________Height______________Weight________________

Occupation_________________________________Company Name___________________________

Spouse's/Partner's Name______________________________Contact #________________________

Primary Physician______________________________Physician Phone #________________________

Date of last complete physical exam______________________

How did you hear about us?____

Emergency Contact

Another person we may contact if needed:

Name____

Relationship_______________________________________

Home Phone__________________________________Work Phone_______________________________

Insurance

Insured Name____Insured DOB:______________

Name of Insurance Co._____________________________________

Insurance Co. Contact Number______________________________

Insured ID Number____

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Health History

What is your primary health concern and the date this started?________________________________

____

Symptoms you are having:____

Have you ever had this difficulty or a similar one before? If yes, please explain:_______________

____

Is it getting Better Worse or Staying the same? *(Circle one)*

What makes it better?____

What makes it worse?____

Level of severity 0-10 (0=None 10=Worst) 1 2 3 4 5 6 7 8 9 10

Timing: Constant Intermittant

Morning Afternoon Evening While Sleeping

Certain Activities (explain)____

Are you currently under a practitioner's care? Yes or No Who: ______________________

MD/Acupuncturist/Herbalist/Nutritionist/Therapist/Chiropractor/Other___________________

X-Rays/CAT Scans/MRI's/NMR's/Bloodwork/Special Studies?______________________________

____

What was the Diagnosis?____

What were the results of treatment?____

Childhoold Illnesses *(please circle any that you have had)*

Scarlet Fever Diphtheria Rheumatic Fever Mumps Measles German Measles Chicken Pox

Allergies?____

Current Medications, Supplements, Herbs?____

Health History……Continued.

Please list a chronological health and major life events history, from earliest to most recent:

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Health History……Continued.

*Please **circle** any that you experience now and **underline** any that you have experienced in the past*

Energy and Immunity

How is your energy? Please circle. *Low* 1 2 3 4 5 6 7 8 9 10 *High*

Do you fatigue easily? Yes No

How would you describe the state of your immune system? Excellent Good Fair Poor

Do you experience: Slow wound healing Chronic Infections Chronic Fatigue Syndrome

Emotional

How do you feel emotionally?______________________________Are you Happy?______________

Do you experience: Anxiety Depression Panic Attacks Nervousness Mood Swings

Do you experience any of the following emotions excessively in your opinion?

Anger Fear Worry Grief Joy

Sleep

How many hours per night do you sleep?______________________

Do you experience: Insomnia Drowsiness Excessive or disturbing dreams

Do you have difficulty: Falling Asleep Staying Asleep Waking Early (Time__________)

Head, Eyes, Ears, & Nose

Headaches	Blurred/Impaired Vision	Impaired Hearing	Sinus Problems
Migraines	Eye Pain/Strain	Ear Ringing	Nosebleeds
Dizziness/Vertigo	Glaucoma	Earaches	Frequent Colds
Memory Loss	Tearing/Dryness	Ear Discharge	Hay Fever

Mouth & Throat

TMJ/Jaw Problems	Difficulty Swallowing	Dental/Gum Problems
Tongue Problems	Unusual Tastes	Frequent Sore Throats

Health History……Continued.

Respiration

Asthma	Frequent Common Colds	Shortness of Breath
Difficulty Inhaling	Pneumonia	Emphysema
Difficulty Exhaling	Pleurisy	Tuberculosis

Cardiovascular

Atherosclerosis	Palpitations/Fluttering	Swelling of the Ankles	Heart Murmurs
High Cholesterol	High Blood Pressure	Difficulty Lying Flat	Heart Disease
Chest Pain/Angina	Low Blood Pressure	Stroke	Heart Attack
Pacemaker	Anemia	Bleed Easily	Bruise Easily
Varicose Veins	Cold Limbs, Hands or Feet	Other_______________________	

Gastrointestinal

Belching	Always Thirsty	Ulcers	Loose Stools
Heartburn/Acid Reflux	Never Thirsty	Gall Bladder Disease	Diarrhea
Epigastric Pain	Crave Cold/Hot Liquids	Liver Disease	Undigested Food
Bloating	High/Low Appetite	Hepatitis A, B, C, D, E	Hemorrhoids
Gas	Celiac's Disease	Irregular Bowel Movements	Anal Itching
Bad Breath	Stomach Pain	Constipation	Blood in Stools
Nausea/Vomiting	Abdominal Pain	Burning Sense	Parasites

Urination

Cloudy Urine	Urinary Dribbling	Urgent Urination
Blood in Urine	Incontinence	Urinary Retention
Burning Pain	Frequent Urination	Trouble Starting Stream
Urinary Tract Infections	Frequent Urination at Night	Kidney Stones or Disease

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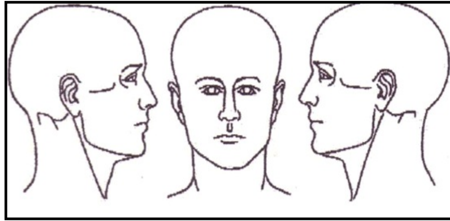
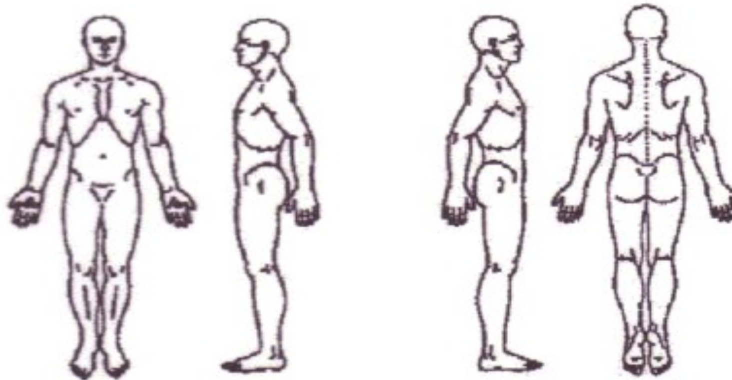
Health History……Continued.

*Please **circle** any that you experience now and **underline** any that you have experienced in the past*

Musculoskeletal (Muscles/Bones/Joints)

Do you have any pain or tightness? Yes / No. If yes, please indicate the location in the chart below:





Quality of Pain *(Circle all that apply)*

Sharp Dull Aching Numb Tingling Burning Throbbing

Shooting Cramping Spasmodic Superficial Deep Swollen Stiff

Worse/Better with Heat Worse/Better with Cold Worse/Better with Pressure

I have (*Circle all that apply)*

Swollen Joints Arthritis/joint pain Tendonitis Muscle Cramping

Bone Pain Repetitive Strain Injury Muscle Pain Reduced Range of motion

Activities of Daily Living are: Normal Mildly Affected Severely Affected

What number best describes your pain now? *No Pain* 1 2 3 4 5 6 7 8 9 10 *Worst Pain*

Date and Nature of Onset:____

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Health History……Continued.

*Please **circle** any that you experience now and **underline** any that you have experienced in the past*

Skin

Rashes	Dryness	Moles/Lumps that change	Lumps that don't change	Itchiness

Endocrine

Hypo-/Hyperthyroid	Hypoglycemia	Diabetes Mellitus
Feeling Hot or Cold	Night Sweats/Spontaneous Sweats	Hot Palms or Soles of Feet

Neurologic

Nervousness	Tremors	Numbness or Tingling
Convulsions	Lack of Coordination	Nerve Pain
Seizures/Epilepsy	Loss of Balance	Paralysis

Men

Prostate Problems	Premature Ejaculation	Sexual Difficulties
Urinary Frequency	Seminal Emission (without Sexual Stimulation)	Reduced Libido
Genital Pain/Swelling	Genital Discharge	Excessive Libido

Other

Arthritis	Gout	STD's	Herpes	HIV/AIDS	Other Infectious Disease

Cancer, Type___________________________ Weight Loss (Intentional? Y/N) Weight Gain

Anything Else?____

____

____

____

____

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Lifestyle

Current Nutritional Orientation________________________________For how long?___________________

Do you typically eat at least three meals per day? Yes No At regular times?____________

Breakfast____

Lunch____

Dinner____

Snacks____

Drink____

Are you more than 20% over your ideal body weight? Yes/No

Are you more than 20% under your ideal body weight? Yes/No

Do you have a stressful occupation? Yes/No

Current Exercise____How Often?_____________________

Relaxation/Meditation/Spiritual Practice____

Circle any of the following that is/are a part of your lifestyle, and note how often:

Smoke___________________Drink Alcohol____________________Drink Coffee___________________

Use Sugar________________Recreational Drugs________________Watch TV______________________

History of Abuse_________Of What?________________________Soft Drinks____________________

Family Health History

Please Circle and Specify Who

Alcoholism	Arteriosclerosis	Diabetes	Liver Disease
Allergies (list)	Asthma	Heart Disease	Mental Illness
____________________	Autoimmunity	High Blood Pressure	Seizures
____________________	Cancer	Kidney Disease	Stroke

Other:____

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Questions for Women Only:

Menstrual Cycle

Are there any problems with your menstural cycle? ______________________________

Has it changed? ______________________________

What do you experience? If it's changing, indicate how:

	Before	During	After	Mid-Cycle
Painful or Swollen Breasts				
Irritability				
Depression or Crying				
Bloating, Loose Stools, or Low Appetite				
Food Cravings				
Nausea				
Cramps or Low Back Pain				
Heavy Bleeding				
Light Bleeding				
Dark Blood (red, purple, or brown?)				
Light Blood				
Thick Blood				
Watery Blood				
Clotting (small, medium, large?)				
Stop and Start again				
Spotting				
Irregular (Short, long, variable?)				
Other:				

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Menstrual Cycle Continued…

How many days are there from one period to the next? ____________________

How many days of bleeding? __________ How does the flow vary? ____________________

If your periods are painful, what do you do to relieve the pain? (Hot, Cold, Pressure, etc?)

____

Age at first menstruation __________ Physical symptoms or emotional changes: ____________________

____

Age period stopped __________ Physical symptoms or emotional changes: ____________________

____

If hysterectomy, when, why and what was removed: ____________________

Vaginal Discharge

Circle any current and underline any past:

Normal	Bad Odor	Itching	Other:
Watery or Thick	Yellow, White, or Clear	Dryness	__________

Breasts

Unusual lactation or discharge__________ Fibroids or Cysts __________

Soreness__________ When __________ Do you do a monthly self-exam? __________

History of breast cancer in your family? ____________________

Have you had a mammogram? __________ If so, Why? ____________________

Signature

The Information provided on this form is correct to the best of my knowledge

Signature____________________Date__________