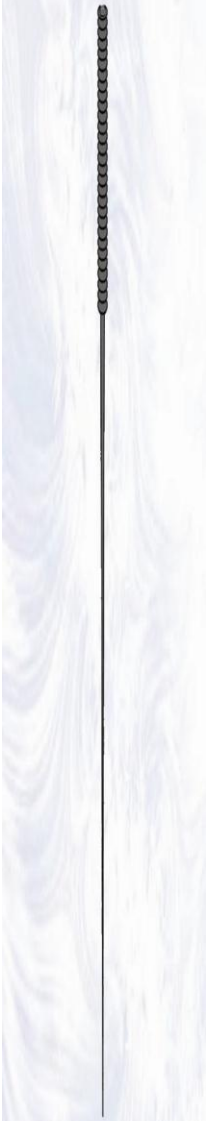
Healing Cycles

Acupuncture

Herbal Medicine

Qi Gong



9034 Krueger St
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Los Angeles
California 90232
310-280-0438

Patient Health History

Name: _____ Date: ___/___/____
(first) (middle) (last)

Date of Birth: _____/_____/_____ Age: _____ Gender: M F

Place of birth: _____

Current Address: _____
(Street) (State) (Zip Code)

E-mail address:_____ Home Phone:_____

Cell Phone_____ Work Phone:_____

Please indicate which phone I should contact you: _____

Contact person's name and phone number: _____

Method of payment (please circle the one that applies): Check Cash Paypal

Successful health care and preventative medicine are only possible when the practitioner has a complete understanding of the patient physically, mentally and emotionally. Please complete this questionnaire as thoroughly as possible. Print all information and indicate areas of confusion with a question mark. Thank you.

1. When and where did you last receive health care and for what reason?

_____

2. Please identify the health concerns that have brought you to our office in order of importance below:

Condition **Past Treatment**

a. _____

How does this condition affect you?_____

b. _____

How does this condition affect you?_____

c. _____

How does this condition affect you?_____

4. If applicable, please list any foods, drugs, or medications you are hypersensitive or allergic to (please include reaction):_____

_____

5. Please list any medications (prescribed and over-the-counter), vitamins, and supplements you are currently taking:_____

_____

_____

6. Do you have any reason to believe you may be pregnant? Y N

If so, how far along are you?_____

7. Do you have any infectious diseases? Y N If yes, please identify: _____

8. **Family History** Check those applicable	Father	Mother	Siblings
Age (if living)	_____	_____	_____
Health (G=Good, P=Poor)	_____	_____	_____
Cancer	_____	_____	_____
Diabetes	_____	_____	_____
Heart Disease	_____	_____	_____
High Blood Pressure	_____	_____	_____
Stroke	_____	_____	_____
Mental Illness	_____	_____	_____
Asthma/Hay fever/Hives	_____	_____	_____
Kidney Disease	_____	_____	_____
Age (at death)	_____	_____	_____
Cause of Death	_____	_____	_____

9. **Height:** _____**Weight:** Currently: _____ Past Maximum: _____When? _____

10. **Blood Pressure:** What is your most recent blood pressure reading? _____/_____ When? _____

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

Scarlet Fever Diphtheria Rheumatic Fever Mumps Measles German Measles

Chicken Pox

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

Polio Tetanus Rubella/Mumps/Rubella Pertussis Diphtheria Hepatitis B

Others:_____

13. **Hospitalizations and Surgeries:**

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

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

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

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

Mood Swings Nervousness Mental Tension

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

Fatigue Slow Wound Healing Chronic Infections Chronic Fatigue Syndrome

17. **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	

18. **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: _____		

19. **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	
Palpitations/Fluttering	Stroke	Heart Murmurs	Rheumatic Fever	Varicose Veins

20. **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

21. **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 UTI Frequent Urination

Heavy Flow Kidney Stones Impaired Urination Blood in Urine

Frequent Urination at Night

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

Irregular Cycles Breast Lumps/Tenderness Nipple Discharge Heavy Flow

Vaginal Discharge Premenstrual Problems Clotting Bleeding Between Cycles

Menopausal Symptoms Difficulty Conceiving Painful Periods

23. **Menstrual/Birthing History:**

1. Age of First Menses: _____ 4. Birth Control Type: _____ 7. # of Abortions: _____

2. # of Days of Menses: _____ 5. # of Pregnancies: _____ 8. # of Live Births: _____

3. Length of Cycle: _____ 6. # of Miscarriages: _____

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

Sexual Difficulties Prostrate Problems Testicular Pain/Swelling Penile Discharge

25. **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?): _____

26. **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

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

Hypothyroid Hypoglycemia Hyperthyroid Diabetes Mellitus Night Sweats

Feeling Hot or Cold

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

Anemia Cancer Rashes Eczema/Hives Cold Hands/Feet

Is there anything else we should know? _____

_____

29. **Lifestyle:**

a. Do you typically eat at least three meals per day? Y N If no, how many? _____

b. Exercise routine: _____

c. Spiritual practice: _____

d. How many hours per night do you sleep? _____ Do you wake rested? Y N

e. Occupation: _____ Hours/Week: _____

Do you enjoy work? Y N Why/Why not?_____

f. Nicotine/Alcohol/Caffeine Use:_____

g. Have you experienced any major traumas? Y N Explain: _____

_____

h. How many glasses of non-caffeinated, non-carbonated beverages do you drink per day? _____

i. Interests and hobbies: _____

Signature:

_____

Thank you for taking your time!!!!

Yamin Chehin L.Ac., D.OM