

WISDOM TRADITIONS

HEALTHCARE CENTER

Health History Questionnaire

Please help us provide you with a complete evaluation by taking the time to fill out this questionnaire carefully. All of your answers will be held absolutely confidential. If you have questions, please ask. If there is anything you wish to bring to our attention which is not asked on this form, please note it in the Comments section. Thank you.

First and Last Name: _____		
Street: _____	City: _____	State: ____ Zip: _____
Age: _____	Height: _____	Weight: _____
Home Phone: _____	Work Phone: _____	Cell Phone: _____
Place / Date of Birth: _____	Social Security Number: _____	
Occupation: _____	Marital Status: _____	
Emergency Contact Name: _____	Phone: _____	Relationship: _____
Referred by: _____	Family Physician: _____	
Have you tried acupuncture or Chinese herbal medicine before? : _____		

MAIN PROBLEM(S) YOU WOULD LIKE TO ADDRESS: _____

To what extent does this problem affect your daily activities (work, sleep, eating, etc.)? _____

How long has it been since you first noticed any symptoms? _____

Have you been given a diagnosis for the problem by your family physician? _____

If so, what is it? _____

What kinds of treatment have you tried? _____

PAST MEDICAL HISTORY (Please Include Dates):

- | | | |
|---|--|--|
| <input type="checkbox"/> Allergies _____ | <input type="checkbox"/> Cancer _____ | <input type="checkbox"/> Diabetes _____ |
| <input type="checkbox"/> Hepatitis _____ | <input type="checkbox"/> Seizures _____ | <input type="checkbox"/> Heart Disease _____ |
| <input type="checkbox"/> Surgeries _____ | <input type="checkbox"/> Rheumatic Fever _____ | <input type="checkbox"/> Thyroid Disease _____ |
| <input type="checkbox"/> Venereal Disease _____ | <input type="checkbox"/> High Blood Pressure _____ | |

Other significant Illness (describe): _____

Accidents or Significant Trauma (describe): _____

Birth History (prolonged labor, forceps delivery, etc): _____

OTHER RELEVANT MEDICAL HISTORY:

**PLEASE PUT A CHECK NEXT TO CONDITIONS YOU HAVE EXPERIENCED WITHIN THE LAST SIX TO NINE MONTHS.
INDICATE THE LENGTH OF TIME YOU HAVE HAD THIS CONDITION:**

GENERAL:

- Poor appetite _____
 - Localized weakness _____
 - Weight gain _____
 - Sweating easily _____
 - Night Sweats _____
 - Poor balance _____
 - Insomnia _____
 - Cravings _____
 - Weight loss _____
 - Tremors _____
 - Chills _____
 - Sudden energy drop (time of day?) _____
 - Disturbed sleep _____
 - Strong thirst _____
 - Changes in appetite _____
 - Bleeding or bruising easily _____
 - Fever _____
- Other unusual or abnormal conditions you have noticed in your general sense of health?
-

SKIN AND HAIR:

- Rashes _____
 - Itching _____
 - Dandruff _____
 - Changes in hair or skin texture _____
 - Ulcerations _____
 - Eczema _____
 - Hair loss _____
 - Hives _____
 - Pimples _____
 - Recent moles _____
- Any other hair or skin problems?
-

HEAD, EYES, EARS, NOSE, THROAT

- Dizziness _____
- Glasses _____
- Poor vision _____
- Cataracts _____
- Ringing in ears _____
- Sinus problems _____
- Teeth problems _____
- Headaches (Where? When?) _____
- Concussions _____
- Spots in front of eyes _____
- Night blindness _____
- Blurry vision _____
- Poor Hearing _____
- Nose bleeds _____
- Recurrent sore throats _____
- Migraines _____
- Eye pain _____
- Color blindness _____
- Earaches _____
- Eyestrain _____
- Jaw clicks _____

CARDIOVASCULAR

- Dizziness _____
 - Irregular heartbeat _____
 - Cold hands or feet _____
 - Blood clots _____
 - Low blood pressure _____
 - High blood pressure _____
 - Swelling of hands _____
 - Difficulty in breathing _____
 - Chest pain _____
 - Fainting _____
 - Swelling of feet _____
 - Phlebitis _____
- Any other heart or blood vessel problems?
-

RESPIRATORY

- Cough _____
 - Bronchitis _____
 - Difficulty breathing when lying down _____
 - Coughing up blood _____
 - Pain with deep inhalation _____
 - Production of phlegm (color?) _____
 - Asthma _____
 - Pneumonia _____
- Any other lung problems? _____
-

GASTROINTESTINAL

- Nausea _____
 - Vomiting _____
 - Diarrhea _____
 - Constipation _____
 - Gas _____
 - Belching _____
 - Black stools _____
 - Blood in stools _____
 - Indigestion _____
 - Bad breath _____
 - Rectal pain _____
 - Hemorrhoids _____
 - Abdominal pain or cramps _____
 - Chronic laxative use _____
- Any other problems with stomach or intestines? _____

GENITO-URINARY

- Pain on urination _____
 - Frequent urination _____
 - Blood in urine _____
 - Urgency to urinate _____
 - Unable to hold urine _____
 - Kidney stones _____
 - Decrease in flow _____
 - Impotence _____
 - Sores on genitals _____
- Do you wake up at night to urinate? _____ If so, how often? _____
- Any particular color to your urine? _____
- Any other problems with your genital or urinary functions? _____

REPRODUCTIVE AND GYNECOLOGICAL

- Menstrual clots _____
 - Painful menses _____
 - Unusual menses _____
 - Changes in body/psyche prior to menstruation _____
 - Heavy or light? _____
 - Irregular menses _____
 - Menopause (age? _____)
 - Other problems _____
- Age at first menses _____ Length of time between menses _____ Duration _____
- First day of last menses _____ Number of pregnancies _____ Premature births _____
- Miscarriages _____ Abortions _____ Number of births _____
- Do you practice birth control? _____ If so, what type? _____ For how long? _____

MUSCULOSKELETAL

- Neck pain _____
 - Muscle pains _____
 - Knee pain _____
 - Back pain _____
 - Muscle weakness _____
 - Foot/ankle pains _____
 - Hand/wrist pains _____
 - Shoulder pains _____
 - Hip pain _____
- Any other joint or bone problems? _____

NEUROPSYCHOLOGICAL

- Seizures _____
 - Dizziness _____
 - Loss of balance _____
 - Areas of numbness _____
 - Poor memory _____
 - Lack of coordination _____
 - Concussion _____
 - Depression _____
 - Anxiety _____
 - Bad temper _____
 - Easily susceptible to stress _____
- Have you ever been treated for emotional problems? _____
- Have you ever considered or attempted suicide? _____
- Any other neurological or psychological problems? _____

COMMENTS - Please tell us of any other problems you would like to discuss: _____

FAMILY MEDICAL HISTORY

- Allergies _____
- Cancer _____
- Seizures _____
- Diabetes _____
- Heart Disease _____
- Stroke _____
- Asthma _____
- High Blood Pressure _____
- Other _____

OCCUPATION: _____

Occupational stress factors (physical, psychological, chemical): _____

LIFESTYLE

Do you follow a regular exercise program? _____ If so, please describe: _____

Please describe your average daily diet: _____

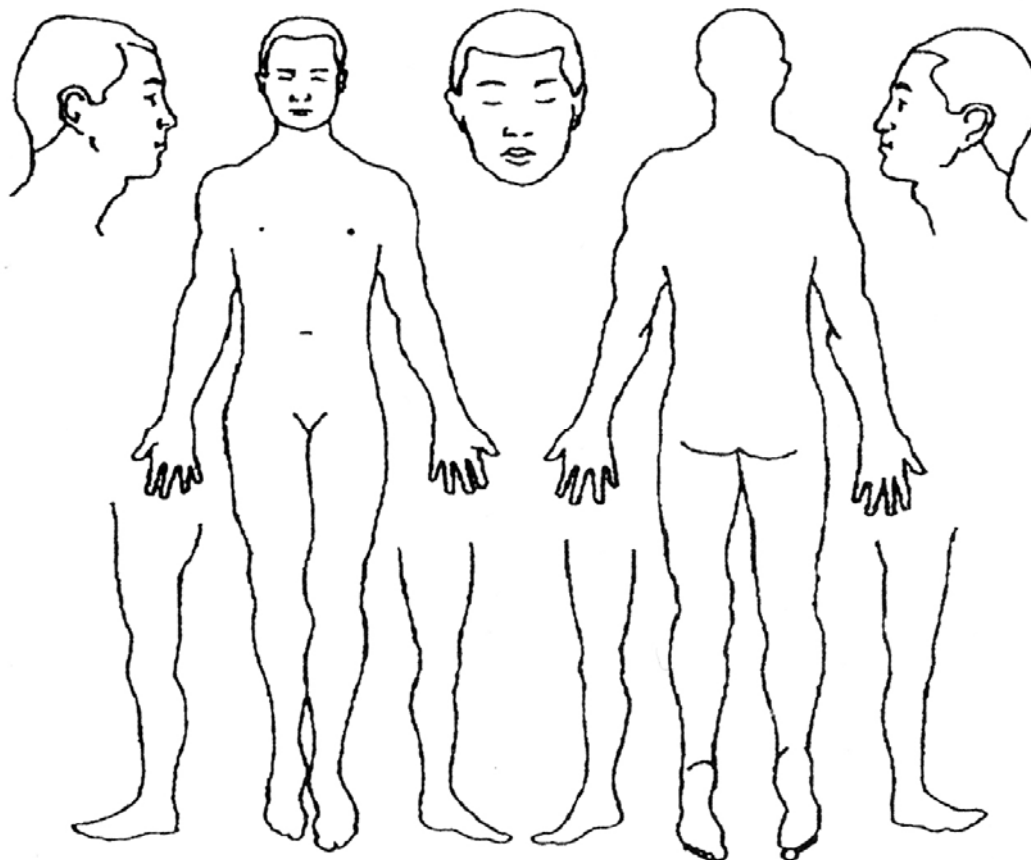
Please check any of the following habits that apply. Indicate how much and how often you consume them:

- Cigarette smoking _____
- Coffee, tea or cola _____
- Alcoholic beverages _____

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

INDICATED PAINFUL OR DISRESSED AREA

- x = little
- xx = moderate
- xxx = strong



Medical Insurance Information

Full Name _____ Date of Birth _____

Address _____ City, State, Zip _____

Social Security Number _____

Insurance Company _____

Insurance Co. Contact Number _____

If using Motor Vehicle Insurance: Adjuster's Name _____

Claim # _____

If Worker's Compensation: Case Worker's Name _____

Claim # _____

Medical Billing Information & Financial Policy

I hereby authorize my insurance company, including private medical insurance and my other health plan to pay benefits to which I am entitled for services rendered by Wisdom Traditions Wellness, LLC. This will remain in effect until revoked by me in writing. I understand that I am responsible for all charges whether or not paid by my insurance. I authorize Wisdom Traditions Wellness LLC, to release information necessary to secure payment of benefits; I authorize the use of my signature on all insurance submissions. I also authorize the release of medical records, reports, and other pertinent information to my referring physician or any other medical personnel involved with the prescribed treatment initiated. I understand that billing services are provided by Wisdom Traditions Wellness LLC, and I authorize faxing of this information. All unpaid account balances will be considered delinquent sixty days from date of charge, I will be informed of the balance and the balance will be charged to me on my credit card supplied on this document. Any delinquent account referred to a collection agency after 90 days will be responsible for the cost of the collection incurred by Wisdom Traditions Wellness LLC, including attorney's fees.

I _____ (print name), have read and fully understand the above policy.

Signature _____ Date _____

Credit Card # (Visa/MC) _____ Expiration Date _____

Patient Consent to receive Mail and/or Telephone Messages.

(Last Name)

(First Name)

(Middle Initial)

(Email Address)

(Home Phone)

(Work/Cell Phone)

DO WE HAVE YOUR PERMISSION TO:

Email you? Y____ N____

Leave Message? Y____ N____

Call you at home? Y____ N____

Leave Message? Y____ N____

Call you at work? Y____ N____

Leave Message? Y____ N____

Call your cell phone? Y____ N____

Leave Message? Y____ N____

Leave medical information on your answering machine?

At home? Y____ N____

At work? Y____ N____

Send an appointment reminder to your home? Y____ N____

Can we call you by your name?
(If no, how would you prefer to be addressed?) Y____ N____

Share your medical and/or appointment information with another person?

Name of person: _____ Y____ N____

Relationship: _____

Share your billing information with another person?

Name of person: _____ Y____ N____

Relationship: _____

May a family member come back into the treatment room?

Name of Person: _____ Y____ N____

Signature of Patient

Date