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PATIENT HEALTH HISTORY

Welcome to the practice of Michelle LaPointe L.Ac., MSOM, LMT. To provide you with the best care, it is necessary that we have a complete understanding of who you are physically, mentally, and emotionally. Please clearly answer the following questions to the best of your ability. Thank you for taking the time to fill out this form completely.

ALL INFORMATION WILL REMAIN CONFIDENTIAL

NAME: _____ **DATE**: __/__/__

Date of Birth: __/__/___ **Age**:_____ **Gender**: M / F **Martial Status**: _____

Occupation: _____ **Height**: _____ **Weight**: _____

Phone: _____ **Email Address** _____

Would you prefer to be contacted by (circle one): EMAIL PHONE

Emergency Contact: _____ **Phone:** _____ **Relationship:** _____

When did you last receive health care from a primary care physician or other health practitioner?

_____

What was the reason?

_____

In order of importance, please list the reason(s) you are seeking care at Four Points Acupuncture and how they are affecting you and your life:

A:_____

B:_____

C:_____

D:_____

E:_____

Please list any allergies or sensitivities you have (foods, drugs, environmental factors etc.)

_____

Please list below:

MEDICATIONS (Prescribed and over the counter)

Medication	Dosage	Date Started	Reason

VITAMINS, SUPPLEMENTS, HERBS

Product	Amount	Date Started	Reason

MEDICAL HISTORY

Please circle any current health issue. For those that have happened in the past, please note the year of the occurrence to the best of your ability.

Allergies	Epilepsy	Scarlet Fever
Anemia	Faitgue	Stroke
Appendicitis	Gout	Surgery (list)
Asthma	Heart Disease	_____
Bleeding Disorder	Hepatitis (A, B, C)	_____
Blood Pressure (LOW/	Hypoglycemia	_____
HIGH)	Injuries	Thyroid Disorder
Cancer	Insomnia	Tuberculosis
Chicken Pox	Intestinal Parasites	Ulcers
Diabetes	Multiple Sclerosis	Weight Loss/Gain
Digestive Disorders	Mumps	
Emotional Difficulty	Pacemaker	
Emphysema	Polio	

Which of the following are part of your lifestyle? How frequently do you engage in it?

Alcohol _____ Caffiene _____ Tobacco _____

Recreational Drugs _____ Excessive Sugar _____

EXERCISE

Do you exercise? _____ **How often?** _____

What activities do you participate in? _____

How do you feel after exercise? _____

DIET

Do you eat three meals a day? _____

Do you follow any particular diet? If so, please describe:_____

Are there any foods that you avoid or are allergic to? _____

EMOTIONS

How would you describe your current emotional state? _____

How would you rate your current level of stress? (1, low-10, high)_____

How do you feel when you get stressed? (emotions, headaches, pain etc.)

What helps you feel less stressed?

_____

_____

REVIEW OF SYSTEMS

Please read carefully. It is important to be aware of any symptoms you are or have been experiencing to get a better picture of your health. Please circle any symptom or state that you have experienced in the past or any one that you are currently experiencing. We will discuss these in further detail at your appointment.

Head and Face	Eyes	Nose	Mouth	Throat
Headaches	Blurry Vision	Sinus Congestion	Dental Problems	Sore Throat
Dizziness	Eyelid Twitching	Bleeding	Bleeding Gums	Hoarseness
Memory Loss	Floaters	Frequent Colds	Grinding Teeth	Difficulty Swallowing
Migraines	Pain	Other_____	TMJ	Dryness
Vertigo	Decreased Night Vision		Unusual Tastes	Swollen Glands
Other_____	Other_____		Other_____	Other_____

Respiration	Heart and Chest	Circulation
Shortness of Breath	Chest Pain	Easy Bruising
Asthma	Chest Tightness	Easy Bleeding
Difficulty Inhaling	Difficulty Laying down	Cold Limbs, Hands, Feet
Difficulty Exhaling	Palpitations	Reynauds' Syndrome
Pain	High Blood Pressure	Other_____
Cough	Low Blood Pressure	
Congestion	Other_____	
Other_____		

Gastrointestinal	Urination	Skin
Excessive Appetite	Frequent	Acne
Low Appetite	Difficult	Dryness
Gas/Bloating	Burning	Changing Moles
Stomach/Abdominal Pain	Painful	Lumps
Nausea	Night Time	Excessive Sweating
Vomiting	Bleeding	Night Sweats
Diarrhea/Loose Stools	Other_____	Rarely Sweat
Constipation		Clammy Sensation
Rectal Bleeding		Other_____
Food Allergies		
Other_____		

Neurological	Sleep	Pain
Nervousness/Anxiety	Difficult Falling Asleep	Please List Locations and Describe Below:
Tremors	Frequent Waking	
Numbness/Tingling	Insomnia	
Nerve Pain	Drowsiness	
Poor Coordination	Waking Early	
Other_____	Excessive Dreaming	
	Other_____	

FAMILY HISTORY (please check those boxes applicable)

Condition	Father	Mother	Siblings	Spouse	Children
Age (if living)					
Health					
Cancer (type)					
Diabetes					
Heart Disease					
Stroke					
High Blood Pressure					
Mental Illness					
Respiratory Illness					
Allergies					
Other					

Women's Heath

Number of Pregnacies: _____ Full Term: _____ Abortions: _____ Miscarriages____
Are you currently, or could you be pregnant? _____ If so, how far along? _____
Do you use birth control? _____ If so, what type? _____
Age at first menses: _____ Date of Last Menstrual Period _____
How many days do you bleed? _____
Do you bleed between periods? _____ Do you bleed after intercourse? _____
Have you ever had an abnormal PAP smear or other gynocological lab test?_____
If so, what was found?

_____

Please check any of the following Pre-Menstrual Symptoms that you have experienced:

Breast Tenderness _____ Headaches _____ Nausea/Vomiting _____
Pain _____ Irritability _____ Depression _____ Crying _____ Anger _____
Cravings, if so for what? _____

Please check any applicable menstrual symptoms below:

Short (< 28 days) _____ Long (>28 days) Varied Length _____ Regular _____
Painful _____ If so, Before _____ During _____ After _____
Do you bleed: Heavily _____ Lightly _____ Very Little _____
Clots _____ Early in the cycle _____ During the whole cycle _____

Relative to the blood that comes from a cut or wound, is your menstrual blood:

Same color _____ More pale _____ Purple _____ More Red _____
More Brown _____

How would you describe your sexual energy? Low Normal High

_____

Men's Health

Do you experience any of the following:

Reduced Libido_____ Excessive Libido_____ Impotence_____
Urinary Frequency_____ Premature Ejaculation_____
Genital/Testicular Pain_____ Prostate Issues_____

Other Concerns?

_____

I have provided correct and complete information to the best of my knowledge:

_____ _____
Patient or Guardian Signature **Date**