

**Ren Dao Wellness Center
Holistic Counseling Health History – Part One**

This is a confidential questionnaire to help us determine the best place to start sessions. Please write clearly. Thank you.

Personal Information

Name _____ Date _____

Home Address _____

City _____ State _____ Zip Code _____

Home Phone _____ Work Phone _____ Mobil Phone _____

Occupation _____ Hours of work per week? _____

Email address _____ How often do you check email? _____

Name of person to contact in case of emergency _____ Phone _____

Who should we thank for referring you to the office? _____

Health History

Sex: Male Female Height: _____ Weight: _____ Birthday: _____ Age: _____

Marital Status: Married Single Divorced Widowed Number of children? _____ Place of Birth? _____

How is the health of your mother? _____ Time of Birth? _____ am pm

How is the health of your father? _____

How is the health of your Siblings? _____

Please indicate any significant illnesses you or a blood relative (Grandparent, parent or sibling) have had:

	You	Your Relative	Approx Date		You	Your Relative	Approx Date
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	_____	Heart	<input type="checkbox"/>	<input type="checkbox"/>	_____
High Blood				Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Pressure	<input type="checkbox"/>	<input type="checkbox"/>	_____	Seizures	<input type="checkbox"/>	<input type="checkbox"/>	_____
Rheumatic				Emotional	<input type="checkbox"/>	<input type="checkbox"/>	_____
Fever	<input type="checkbox"/>	<input type="checkbox"/>	_____	Disorders	<input type="checkbox"/>	<input type="checkbox"/>	_____
Infectious				Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diseases	<input type="checkbox"/>	<input type="checkbox"/>	_____				

Other Illnesses or health issues: _____

Blood Type? _____

Sexually Transmitted Diseases: Gonorrhea Syphilis AIDS HPV Chlamydia Herpes Date _____

List any medications and supplements you are currently taking. Continue on back if necessary.

Medicine	Dosage	Reason	How long	Prescribed by	Date of last checkup

Please enter the use and frequency of the following:

<input type="checkbox"/> Tobacco _____#cigarettes/packs per day	_____Age started	<input type="checkbox"/> Stopped - Date_____
<input type="checkbox"/> Caffeine _____#coffees/day _____# teas/day _____#colas/day	_____Age started	<input type="checkbox"/> Stopped - Date_____
<input type="checkbox"/> Alcohol _____# drinks per week	_____Age started	<input type="checkbox"/> Stopped - Date_____
<input type="checkbox"/> Street drugs - Specify drug_____	_____Age started	<input type="checkbox"/> Stopped - Date_____
Frequency of use_____		
<input type="checkbox"/> Water Intake _____# cups per day		
<input type="checkbox"/> Cold <input type="checkbox"/> Room Temperature <input type="checkbox"/> Warm		

For Women

Age of 1st period (menarche) _____ Are you Pregnant? Yes No Number of pregnancies _____
 Age of last period (menopause) _____ # of live births _____ # of Abortions _____ # of Miscarriages _____
 Number of days between periods _____ Date of last Gynecologic exam _____ Pap Smear _____
 Color of flow _____ Results _____

Clots? Yes No Color _____
 Average number of pads you use per day 1st day _____ 2nd day _____ 3rd day _____ 4th day _____ 5th day _____
 Have you been diagnosed with: Fibroids Fibrocystic Breasts Endometriosis Ovarian Cysts PID
 Other _____

Location of Pain: Lower abdomen Lower back Thighs Other _____

Nature of Pain (Please indicate Before, During or After menses) Other Symptoms related to menses

Cramping _____	Stabbing _____	<input type="checkbox"/> Discharge	<input type="checkbox"/> Vaginal dryness	<input type="checkbox"/> Headache
Burning _____	Aching _____	<input type="checkbox"/> Nausea	<input type="checkbox"/> Constipation	<input type="checkbox"/> Diarrhea
Dull _____	Bloating _____	<input type="checkbox"/> Swollen breasts	<input type="checkbox"/> Mood Swings	<input type="checkbox"/> Ravenous appetite
Consistent _____	Intermittent _____	<input type="checkbox"/> Poor appetite	<input type="checkbox"/> Hot flashes	<input type="checkbox"/> Night sweats
Bearing down sensation _____		<input type="checkbox"/> Increased libido	<input type="checkbox"/> Decreased libido	<input type="checkbox"/> Insomnia

For Men

Date of last prostate check up _____ PSA results _____ Manual prostate exam results _____

Lab Results _____

Frequency of urination: Daytime _____ Nighttime _____ Color of urine: clear murky. Odor _____

Symptoms related to prostate

<input type="checkbox"/> Prostrate problems	<input type="checkbox"/> Delayed stream	<input type="checkbox"/> Dribbling	<input type="checkbox"/> Incontinence	<input type="checkbox"/> Retention of urine
<input type="checkbox"/> Rectal dysfunction	<input type="checkbox"/> Increased libido	<input type="checkbox"/> Decreased libido	<input type="checkbox"/> Premature ejaculation	<input type="checkbox"/> Impotence
<input type="checkbox"/> Back pain	<input type="checkbox"/> Groin pain	<input type="checkbox"/> Testicular pain	<input type="checkbox"/> Other _____	

Symptom Survey (for Everyone)

The following is a list of symptoms that you may or may not ever experience. Please indicate as follows:

no mark () = never experience check mark (√) = sometimes experience (+) = frequently experience

___ lack of appetite	___ abdominal pain	___ eye problems	___ fatigue
___ excessive appetite	___ chest pain	___ jaundice (yellowish	___ edema
___ loose stool or diarrhea	___ sciatic pain	eyes or skin)	___ blood in stool
___ indigestion	___ headaches	___ difficult digesting	___ black tarry stool
___ vomiting	___ pain or coldness in the	oily foods	___ easily bruised
___ belching, burping	genital area	___ gall stones	___ difficult to stop bleeding
___ heartburn / reflux	=====	___ light colored stool	___ asthma
___ feeling of retention of	___ cough	___ soft brittle nails	___ tendency to catch colds
food in stomach	___ decrease sense of smell	___ easily angered or	easily
___ tendency to become	___ nasal problems	agitated	___ intolerance to weather
obsessive in work or	___ skin problems	___ difficulty in making	changes
relationships	___ feeling of	plans or decisions	___ allergies
=====	claustrophobia	___ spasms or twitching	___ hay fever
___ insomnia, difficulty	___ bronchitis	of muscles	___ dizziness
sleeping	___ colitis or	=====	___ high cholesterol level
___ heart palpitation	diverticulitis	___ lower back pain	___ sudden weight loss
___ cold hand and feet	___ constipation	___ knee problems	___ urinary problems
___ nightmares	___ hemorrhoids	___ hearing impairment	
___ laughing for no	___ recent use of	___ ear ringing	
apparent reason	antibiotics	___ kidney stones	
___ angina pain		___ hair loss	

Current weight _____ Six months ago _____ One year ago _____ Five years ago _____ Ten years ago _____

Would you like your weight to be different? _____ If so, what? _____

Do you sleep well? _____ Do you wake up nights? _____ What times? _____ How often? _____ To urinate? _____

What time do you generally go to bed? _____ What time do you get up in the morning? _____

What role does exercise play in your life? _____

Please list any healers, helpers, or therapies with which you are involved? _____

Ren Dao Wellness Center
Holistic Counseling Health History – Part Two

Past and Present Diet History

What foods did you eat often as a child?

<u>Breakfast</u>	<u>Lunch</u>	<u>Dinner</u>	<u>Snacks</u>	<u>Liquids</u>

What about a year ago?

<u>Breakfast</u>	<u>Lunch</u>	<u>Dinner</u>	<u>Snacks</u>	<u>Liquids</u>

What's your food like these days?

<u>Breakfast</u>	<u>Lunch</u>	<u>Dinner</u>	<u>Snacks</u>	<u>Liquids</u>

**Ren Dao Wellness Center
Holistic Counseling Health History – Part Three**

Current Health Concerns

What are the main health concerns for which you are seeking treatment?

What other forms of treatment have you sought?

List any other health concerns you now have?

List any allergies, food sensitivities or food craving that you have?

List any accidents, surgeries, or hospitalizations (include dates).

Lab Results: (please include copies)

Clinical Notes
(For Acupuncturist Use)

How do you feel about the following areas of your life?

Please check the appropriate boxes and indicate any problems you may be experiencing.

	Great	Good	Fair	Poor	Bad	Your Comments
Significant other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<hr/>
Family	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<hr/>
Diet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<hr/>
Sex	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<hr/>
Work	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<hr/>
Exercise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<hr/>
Stress	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<hr/>