Mountain Spirit Acupuncture
12201 Pecos Street Suite 100 Westminster, CO 80234
303-929-7334

Patient Health History (Male)

Name: ____ Birth Date: _____/_____/_____ Age: _____

Address: ____ City: _________________ State: _______ Zip: ________

Preferred Phone #: ________________________________ ☐ Home ☐ Cell ☐ Work Ok to leave messages? ☐ Yes ☐ No

How did you hear about **Mountain Spirit Acupuncture?** ☐ Friend – (Who?) ______________________________ ☐ Internet
☐ Mail-out ☐ MD ☐ Other ______________________________

Emergency Contact: ______________________________ Relation: ___________________________ Phone #: _________________

Successful health care is only possible when the practitioner has a thorough understanding of the patient physically, mentally and emotionally. Please complete the following questionnaire as thoroughly as possible.

Are you currently receiving health care? ☐ Yes ☐ No
If yes, where and from whom? ____
If no, when and where did you last receive health care? ____

MAIN HEALTH CONCERNS

PRIMARY COMPLAINT: ____
Symptoms: ____
____
____

How long have you had this? ____
Is your condition: ☐ Getting worse ☐ Staying constant ☐ Coming & going Have you had this in the past? ☐ Yes ☐ No
How did it begin? ____
What aggravates it? ____
What relieves it? ____
What other healthcare practitioners have you seen about this? ____
Type of care given? ______________________________ Was it effective? ______________________________

SECONDARY COMPLAINT: ____
Symptoms: ____
____
____

How long have you had this? ____
Is your condition: ☐ Getting worse ☐ Staying constant ☐ Coming & going Have you had this in the past? ☐ Yes ☐ No
How did it begin? ____
What aggravates it? ____
What relieves it? ____
What other healthcare practitioners have you seen about this? ____
Type of care given? ______________________________ Was it effective? ______________________________

Are your complaints affecting your ability to work or otherwise be active? ☐ No effect ☐ Yes ☐ Some physical restrictions
☐ Need limited assistance ☐ Need assistance often ☐ Can't care for self

Is today's visit due to a Motor Vehicle Collision? ☐ Yes ☐ No If yes, when? ______________________________
Have you ever had acupuncture before? ☐ Yes ☐ No
Do you have any chronic infections diseases? ☐ Yes ☐ No If yes, explain: ______________________________
Are you suffering from any chronic illnesses? ☐ Yes ☐ No If yes, explain: ______________________________

Significant diseases, injuries, hospitalizations, surgeries, x-ray/CT/MRI/NMR
Reason Date Results (if applicable)

___

___

___

___

Please list any prescription medications, over the counter medications, vitamins or supplements that you are currently taking, and give your dosage.
Medication/Vitamin/Supplement Dosage Frequency Reason

___

___

___

___

___

Please list any foods, drugs, substances or medications you are hypersensitive or allergic to: ___

Please check any immunizations that you have had: □ Polio □Tetanus □ Measles/Mumps/Rubella (MMR) □ Pertussis □ Diphtheria
□ Hepatitis B □ Influenza □ Other: ___

Family History	Mother	Father	Brother(s)	Sister(s)
Age if living				
Health G = Good, P = Poor				
Age at death if deceased				
Cause of death				
Family Illnesses	Mother	Father	Brother(s)	Sister(s)
Allergies				
Cancer				
Diabetes				
Heart Disease				
High Blood Pressure				
Kidney Disease				
Stroke				
Mental Illness				

HEALTH HISTORY

When completing the information below, indicate if it is a CURRENT condition (first box) or a PAST condition (second box):

General Symptoms

C / P
□ □ Poor appetite
□ □ Large appetite
□ □ Strongly like cold drinks
□ □ Strongly like hot drinks
□ □ Peculiar taste
□ □ Cravings
□ □ Sweats easily
□ □ Night sweats
□ □ Prolapsed organs

C / P
□ □ Poor Sleep
□ □ Dream disturbed sleep
□ □ Heavy sleep
□ □ Bodily heaviness
□ □ Chills
□ □ Fever
□ □ Bleed or bruise easily
□ □ Cold hands or feet

C / P
□ □ Poor circulation
□ □ Vertigo or dizziness
□ □ Fatigue
□ □ Lack of strength
□ □ Shortness of breath
□ □ Muscle cramps
□ □ Anemic
□ □ History of Cancer
What type: ___ When: ___

Endocrine and Metabolic Disorders

□ □ Hypothyroidism
□ □ Adrenal burnout / fatigue
□ □ Sweats easily
□ □ Hyperthyroidism
□ □ Diabetes Mellitus
□ □ Weight gain
□ □ Hypoglycemia
□ □ Night sweats
□ □ Weight loss

Head, Eyes, Ears, Nose, Throat

C / P
- ◻ ◻ Headaches
- ◻ ◻ Migraines
- ◻ ◻ Facial pain
- ◻ ◻ Glasses or Contacts
- ◻ ◻ Poor vision
- ◻ ◻ Blurred vision
- ◻ ◻ Eye strain
- ◻ ◻ Red eyes
- ◻ ◻ Itchy eyes
- ◻ ◻ Spots or floaters in eyes

C / P
- ◻ ◻ Glaucoma
- ◻ ◻ Night blindness
- ◻ ◻ Sores on lips or tongue
- ◻ ◻ Swollen glands
- ◻ ◻ Dry mouth
- ◻ ◻ Excessive saliva
- ◻ ◻ Recurrent sore throat
- ◻ ◻ Lumps in throat
- ◻ ◻ TMJ problems
- ◻ ◻ Teeth problems

C / P
- ◻ ◻ Grinding teeth
- ◻ ◻ Sinus problems
- ◻ ◻ Enlarged thyroid
- ◻ ◻ Excessive phlegm
- ◻ ◻ Ear aches
- ◻ ◻ Ringing in ears
- ◻ ◻ Poor hearing
- ◻ ◻ Gum problems
- ◻ ◻ Eye pain
- ◻ ◻ Concussions

Respiratory
- ◻ ◻ Difficulty breathing when lying down
- ◻ ◻ Shortness of breath
- ◻ ◻ Tight chest
- ◻ ◻ Cough Wet or dry (circle one)
- ◻ ◻ Color of phlegm ____________
- ◻ ◻ Coughing blood
- ◻ ◻ Asthma / Wheezing
- ◻ ◻ Pneumonia
- ◻ ◻ Frequent colds
- ◻ ◻ Persistent cough

Cardiovascular
- ◻ ◻ High blood pressure
- ◻ ◻ Tight chest
- ◻ ◻ Chest pain
- ◻ ◻ Pace maker
- ◻ ◻ Fainting
- ◻ ◻ Difficulty breathing
- ◻ ◻ Heart palpitations
- ◻ ◻ Low blood pressure
- ◻ ◻ Irregular heart beat
- ◻ ◻ Heart disease
- ◻ ◻ Blood clots

Are you currently taking Coumadin, Warfarin or any other blood thinners? ◻ Yes ◻ No

Gastrointestinal

Bowel movements:

Frequency: __________________________

Texture/Form: ________________________

Color: ______________________________

Odor: ______________________________

- ◻ ◻ Diarrhea
- ◻ ◻ Constipation
- ◻ ◻ Laxative use
- ◻ ◻ Mucous in stool
- ◻ ◻ Undigested food in stool
- ◻ ◻ Itchy anus
- ◻ ◻ Anal fissures
- ◻ ◻ Black stools
- ◻ ◻ Bloody stools
- ◻ ◻ Gas
- ◻ ◻ Bloating
- ◻ ◻ Intestinal pain or cramping
- ◻ ◻ Burning anus
- ◻ ◻ Rectal pain
- ◻ ◻ Fatigue after eating
- ◻ ◻ Hemorrhoids
- ◻ ◻ Nausea
- ◻ ◻ Vomiting
- ◻ ◻ Acid regurgitation / Heart burn
- ◻ ◻ Bad breath
- ◻ ◻ Frequent hiccups
- ◻ ◻ Gallbladder disease
- ◻ ◻ Liver disease
- ◻ ◻ Incomplete bowel movement

Skin and Hair
- ◻ ◻ Rashes
- ◻ ◻ Eczema
- ◻ ◻ Dandruff
- ◻ ◻ Hair loss
- ◻ ◻ Change in hair / skin texture
- ◻ ◻ Hives
- ◻ ◻ Psoriasis
- ◻ ◻ Itching
- ◻ ◻ Fungal infections
- ◻ ◻ Ulcerations
- ◻ ◻ Acne

Neuropsychological
- ◻ ◻ Seizures
- ◻ ◻ Poor Memory
- ◻ ◻ Irritability
- ◻ ◻ Stroke
- ◻ ◻ Mental tension
- ◻ ◻ Considered or attempted suicide
  When: ____________________
- ◻ ◻ Numbness
- ◻ ◻ Depression
- ◻ ◻ Easily stressed
- ◻ ◻ Mood swings
- ◻ ◻ Anger easily
- ◻ ◻ Tics
- ◻ ◻ Anxiety
- ◻ ◻ Abuse survivor
- ◻ ◻ Mental fogginess
- ◻ ◻ Loss of balance
- ◻ ◻ Paralysis

Genito-Urinary
- ◻ ◻ Pain when urinating
- ◻ ◻ Blood in urine
- ◻ ◻ Venereal disease
- ◻ ◻ Increased libido
- ◻ ◻ Urgency to urinate
- ◻ ◻ Frequent urination
- ◻ ◻ Bed wetting
- ◻ ◻ Unable to hold urine
- ◻ ◻ Decreased libido
- ◻ ◻ Difficulty urinating
- ◻ ◻ Wake to urinate
- ◻ ◻ Incomplete urination
- ◻ ◻ Kidney stone
- ◻ ◻ Incontinence

Urinary output equal to liquid intake? ◻ Yes ◻ No

Musculoskeletal pain
Please fill out the Pain Management Intake

Your diet
Appetite: □ Low □ Strong □ Too busy to notice

C / P
□ □ Coffee (#/day) __________
□ □ Soft drinks (#/day) __________
□ □ Water (#/day) ____________
□ □ Frequent thirst

C / P
□ □ Artificial sweeteners
□ □ Red meat
How frequently: ____________________
□ □ Decreased thirst

C / P
□ □ Energy Drinks
□ □ Dairy
How frequently: ____________________

Yesterday's breakfast: ____ Lunch: ______________________________
Dinner: ________________________________ Snacks: ______________________ Is this a typical day? □ Yes □ No

Your lifestyle
□ □ Alcohol
How often? _________________
□ □ Occupational hazards

□ □ Marijuana
How often? _______________________
□ □ Other recreational drug use

□ □ Tobacco
How much? _______________________

□ □ Exercise Type: ____ Frequency: ________________________
□ □ Stress Cause: ____
Occupation: ________________________________ Hours/week: __________ Do you enjoy your job? □ Yes □ No

Your sleep
□ □ Difficulty falling asleep
□ □ Vivid dreams
□ □ Frequent waking
What time: ________________________
For how long: ______________________

□ □ Difficulty staying asleep
□ □ Good sleep quality

□ □ Wake feeling rested
□ □ Poor sleep quality

Male Reproductive
□ □ Premature ejaculation
□ □ Prostate problems

□ □ Impotence
□ □ Nocturnal emissions

□ □ Erectile Dysfunction

External genitalia have sensations of □ Heat □ Cold □ Pain □ Swelling

Is there anything else about you or your health history you feel we should know about? ________________________________
____
____
____