Optimal Health Center of Santa Rosa
HEALTH HISTORY

Date: ____ / ____ / ______

Name:			Sex:	Age:
Address:		City:	State:	Zip Code:
Home Phone #:	Other Phone #: Work Cell Other	Email:		
Date of Birth:	Employer:	Occupation:		
Health Care Providers:	Relationship Status: ❒ Single ❒ Married ❒ Separated ❒ Divorced ❒ Widowed ❒ Living w/partner ❒ Other: __________			
Height:	Usual Blood Pressure:			
Weight:	Weight One Year Ago:	How did you hear of our clinic?		
For Women: Are you or may you be currently pregnant?	Have you been treated by Acupuncture or Oriental Medicine Before? ❍ No ❍ Yes: when ____/____/____			

MAIN COMPLAINTS

Please write in your top 3 health complaints / concerns in order of importance to you. Circle the items that make it better or worse and mark on the scale from 1-10 the severity of the condition (1=no symptoms, 10=worst ever)

1 ______________________________

When did this start? ________________ago

Heat makes it:	better	no change	worse
Cold makes it:	better	no change	worse
Damp weather:	better	no change	worse
Exercise / Activity:	better	no change	worse

1 |——————|——————| 10

2 ______________________________

When did this start? ________________ago

Heat makes it:	better	no change	worse
Cold makes it:	better	no change	worse
Damp weather:	better	no change	worse
Exercise / Activity:	better	no change	worse

1 |——————|——————| 10

3 ______________________________

When did this start? ________________ago

Heat makes it:	better	no change	worse
Cold makes it:	better	no change	worse
Damp weather:	better	no change	worse
Exercise / Activity:	better	no change	worse

1 |——————|——————| 10

HEALTH HISTORY

Check the ❒ if **you** have / had the condition and note the year it started.
Check the ❍ if there is a family history of the condition.

Condition	YOU	Year	FAMILY
Cancer type(s)? ______________	❒	_______	❍
Diabetes	❒	_______	❍
Hepatitis	❒	_______	❍
High Blood Pressure	❒	_______	❍
Heart Disease	❒	_______	❍
Stroke	❒	_______	❍
Seizure Disorder	❒	_______	❍
Thyroid Disease	❒	_______	❍
Asthma	❒	_______	❍
Pacemaker	❒	_______	❍

Condition	YOU	Year	FAMILY
Osteoporosis	❒	_______	❍
Herpes	❒	_______	❍
AIDS / HIV	❒	_______	❍
Other STD	❒	_______	❍
Rheumatic Fever	❒	_______	❍
Alcoholism	❒	_______	❍
Allergies type(s)? ______________	❒	_______	❍
Mental Illness	❒	_______	❍
Kidney Disease	❒	_______	❍
Anemia	❒	_______	❍

HABITS

	Amount / Week	If Quit, Year?
Coffee / Tea	______________	_______
Soda	______________	_______
Tobacco	______________	_______
Alcohol	______________	_______
Drugs	______________	_______

EXERCISE

Do you exercise regularly? ⑤ Yes ⑤ No

If so, what and how often:

____

____

____

DIET

MEDICATIONS

Please note what medications, herbs or supplements that you take regularly

____

____

____

INJURIES & SURGERIES

Please note what happened to what body area and when it occurred (incl. dental)

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