Wise Wellness Center, LLC
Patient History Form

Name(First Middle Last)_____ Date:____/____/_____

Date of Birth____/____/_____ Age_____ Gender: M/F Marital Status: S M D W

Address:_____City_____State_____Zip_____

Phone: (_____)_____-_____Email:_____
Emergency Contact: (Name)_____Relationship?_____Phone: (__)_____-_____

Occupation?_____Do you exercise regularly? Y/N? Alcohol/Caffeine/Nicotine Use?
Have you received Acupuncture in the past? Y/N If yes, when?_____
Do you have any reason to believe you may be pregnant? Y/N If yes, how far along?_____
Do you have any infectious diseases? Y/N If yes, please identify?_____
Are you on any medications or supplements/vitamins? Y/N If yes, please list_____
_____
Please list all surgeries_____
Do you have any allergies? please list:_____
_____
Are you taking a blood thinner such as coumadin or warfarin? Y/N?
Are you on Steroids? Y/N?
Do you have a pacemaker? Y/N?
Do you suffer from a seizure disorder? Y/N?
Are you taking medication for high blood pressure? Y/N?

Current Weight_____lbs Current Height_____ft____in Current Blood Pressure_____/_____

Please list 2 Main Health Concerns

1)_____

Does this pain/issue interfere with (circle one) Work, Driving, Walking, Sleep, Daily Activities?

Does HEAT make it: (circle one) Better, No Change, Worse
Does COLD make it:(circle one) Better, No Change, Worse
Does HUMIDITY make it: (circle one) Better, No Change, Worse
Exercise/activity make it: (circle one) Better, No Change, Worse

Please rate the intensity of this health concern on a scale of 0 being no pain to 10 being the worst pain you can imagine. Mark “B” for when it is at it’s BEST and “W” for at it’s WORST

0<———-1————2————-3———4———5———6———7———8———9————10

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2)_____

Does this pain/issue interfere with (circle one) Work, Driving, Walking, Sleep, Daily Activities?

Does HEAT make it: (circle one) Better, No Change, Worse
Does COLD make it:(circle one) Better, No Change, Worse
Does HUMIDITY make it: (circle one) Better, No Change, Worse
Exercise/activity make it: (circle one) Better, No Change, Worse
Please rate the intensity of this health concern on a scale of 0 being no pain to 10 being the worst pain you can imagine. Mark “B” for when it is at it’s BEST and “W” for at it’s WORST

0<———-1————2————-3———4———5———6———7———8———9————10

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Are you currently, or have you in the past, experienced any of these symptoms: Circle if current condition, underline if <u>past</u>

Emotions	Energy and Immunity	Respiratory/HEENT	Endocrine
Anxiety	Fatigue	Frequent colds/flu	Thyroid Conditions
Nervousness	Chronic Fatigue	COPD	Hashimoto's Disease
Palpitations	Chronic Infections	Emphysema	Adrenal Fatigue
Stress	Allergies	Asthma	Addison's Disease
Panic attacks		Headaches	Hypoglycemia
Depression		Sinus Issues	Diabetes
		Ear Ringing	

Gastrointestinal	Genitourinary	Female Reproductive	Cardiovascular
Ulcer	UTI's	Painful Menses	Heart Disease
GERD	Kidney disease	Irregular Cycles	High Cholesterol
IBS	Kidney Stones	Endometriosis	High Blood Pressure
Chrons	Frequent Urination	Ovarian Cysts	Stroke
Ulcerative Colitis		Infertility	Irregular Heartbeat
Gallbladder disease		Menopause	
IBD		Night Sweats	
		Spontaneous Sweats	

Muskuloskeletal	Neurological	Other	Male Reproductive
Neck/Shoulder Pain	Dizziness/Vertigo	Anemia	Prostate Problems
Low Back Pain	Seizures/Epilepsy	Cancer	Testicular Pain/Swelling
Muscle Spasm/cramps	Numbness/Tingling	Eczema/Hives	Sexual Difficulties
Leg Pain/Arm Pain	Alzheimers		Frequent Urination
Joint Pain	Parkinson's		
Upper/Mid Back Pain	Migraines		
Arthritis/Osteoarthritis			

How often do you have a bowl movement? ____per/day. Are they: (circle one) generally watery, loose, soft, well-formed, hard, pellets, difficult to evacuate, incomplete feeling, do they vary from loose to hard?
How often do you urinate?_____/day, At night?____ If at night, what time do you wake to urinate?___
Do you crave: (circle one) Beverages that are: Iced, Cold, Room temp., Warm, Hot?
Do you generally feel: (circle one) cold or run warm? Do you have cold hands and feet? Y/N

What time do you go to bed?_____What time do you wake up?_____ Do you wake rested? Y/N?

Your energy from a scale of 0-10, 0 being no energy and 10 your best:
after you wake up? _____ 12-3pm?_____ 5-7pm_____ 7-9pm_____?

Current Stress Level 0 being no stress, 10 being the worst you can imagine?_____

Any significant increase or decrease in appetite in last 6 months? Y/N?
Any Gas, Acid-reflux, GERD, Bloating, Abdominal pain? Y/N? If Yes, circle all that apply

Are you a Smoker? Y/N? If so, How long?_____ How many cig/packs per day?_____

For Women: Age of first menses?____# of days of menses?_____Length of cycle?_____Type of Birth Control?_____# of Pregnancies?____# of Miscarriages?___# of abortions?___# of Live Births?_____

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