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: (_____)_________-__________ May we leave a detailed message? Y/N?

Would you like text reminders? Y/N? Cell Carrier: _______________________________

Email:__________________________________(we send email appt reminders and monthly newsletter)

How did you hear about us? ____

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 past

Emotions

Anxiety
Nervousness
Palpitations
Stress
Panic attacks
Depression

Energy and Immunity

Fatigue
Chronic Fatigue
Chronic Infections
Allergies

Respiratory/HEENT

Frequent colds/flu
COPD
Emphysema
Asthma
Headaches
Sinus Issues
Ear Ringing

Endocrine

Thyroid Conditions
Hashimoto's Disease
Adrenal Fatigue
Addison's Disease
Hypoglycemia
Diabetes

Gastrointestinal

Ulcer
GERD
IBS
Chrons
Ulcerative Colitis
Gallbladder disease
IBD

Genitourinary

UTI's
Kidney disease
Kidney Stones
Frequent Urination

Female Reproductive

Painful Menses
Irregular Cycles
Endometriosis
Ovarian Cysts
Infertility
Menopause
Night Sweats
Spontaneous Sweats

Cardiovascular

Heart Disease
High Cholesterol
High Blood Pressure
Stroke
Irregular Heartbeat

Muskuloskeletal

Neck/Shoulder Pain
Low Back Pain
Muscle Spasm/cramps
Leg Pain/Arm Pain
Joint Pain
Upper/Mid Back Pain
Arthritis/Osteoarthritis

Neurological

Dizziness/Vertigo
Seizures/Epilepsy
Numbness/Tingling
Alzheimers
Parkinson's
Migraines

Other

Anemia
Cancer
Eczema/Hives

Male Reproductive

Prostate Problems
Testicular Pain/Swelling
Sexual Difficulties
Frequent Urination

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?_____