

Sarah Taylor L.Ac.
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Patient Health History

Name: _____ Date: _____

Please identify the health concerns that brought you to the Clinic in order of importance below:

<u>Condition</u>	<u>For how long?</u>	<u>Past treatment that helped this condition</u>
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____

List any foods, drugs, or medications you are hypersensitive or allergic to:

List any medications (prescribed and over-the-counter), herbs, vitamins, and supplements you are currently taking and for what condition they are being taken:

Height: _____ Current weight: _____

Childhood & adulthood major illnesses, accidents, hospitalizations, surgeries:

<u>Event</u>	<u>Date</u>	<u>Event</u>	<u>Date</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Family Medical History (immediate blood relatives)

<input type="checkbox"/> Allergies _____	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Alcoholism
<input type="checkbox"/> Arteriosclerosis	<input type="checkbox"/> Seizures	<input type="checkbox"/> High Blood Pressure
<input type="checkbox"/> Cancer _____	<input type="checkbox"/> Asthma	<input type="checkbox"/> Autoimmune disease _____
<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Stroke	<input type="checkbox"/> Emotional/Psychological Disorder _____
		<input type="checkbox"/> Other _____

Lifestyle: Which of the following is/ are a part of your daily life?

<input type="checkbox"/> Exercise	<input type="checkbox"/> Coffee	<input type="checkbox"/> Dieting
<input type="checkbox"/> Relaxation/meditation	<input type="checkbox"/> Alcohol	<input type="checkbox"/> Stress
<input type="checkbox"/> Tobacco smoking/chewing	<input type="checkbox"/> Recreational drugs	<input type="checkbox"/> Occupational hazards
		<input type="checkbox"/> Other _____

SYMPTOM LIST

Please check symptoms you currently have or have experienced in the past.

Emotional/Psychological			
<input type="checkbox"/> Anxiety	<input type="checkbox"/> Stress	<input type="checkbox"/> Anorexia	<input type="checkbox"/> Chronic sadness/grief
<input type="checkbox"/> Depression	<input type="checkbox"/> Frequent irritability	<input type="checkbox"/> Bulimia	<input type="checkbox"/> Overly fearful
<input type="checkbox"/> Manic	<input type="checkbox"/> Frequent anger	<input type="checkbox"/> Frequent Worry	<input type="checkbox"/> Addictions:
<input type="checkbox"/> Bipolar	<input type="checkbox"/> Mood swings	<input type="checkbox"/> Obsessive/Compulsive	(to what?):_____
Immune& Inflammation			
<input type="checkbox"/> Chronic Fatigue Syndrome	<input type="checkbox"/> Fibromyalgia	<input type="checkbox"/> Hepatitis A, B or C	<input type="checkbox"/> Raynaud's Syndrome
<input type="checkbox"/> Hashimoto's disease	<input type="checkbox"/> Frequent illness	<input type="checkbox"/> Herpes	<input type="checkbox"/> Connective tissue inflammation
<input type="checkbox"/> Grave's disease	<input type="checkbox"/> Frequent infection	<input type="checkbox"/> Chicken pox	<input type="checkbox"/> Food allergies
<input type="checkbox"/> Arthritis_____	<input type="checkbox"/> Hay fever	<input type="checkbox"/> HIV	<input type="checkbox"/> Environmental allergies
<input type="checkbox"/> Lupus	<input type="checkbox"/> Frequent swollen glands	<input type="checkbox"/> Cold sores	<input type="checkbox"/> Seasonal allergies
<input type="checkbox"/> Colitis	<input type="checkbox"/> Cancer	<input type="checkbox"/> Mononucleosis	
<input type="checkbox"/> Crohn's disease			
Eyes, Ears, Nose, Throat & Head			
<input type="checkbox"/> Impaired vision	<input type="checkbox"/> Watery eyes	<input type="checkbox"/> Runny nose	<input type="checkbox"/> Teeth grinding
<input type="checkbox"/> Blurry vision	<input type="checkbox"/> Impaired hearing	<input type="checkbox"/> Sinus problems	<input type="checkbox"/> Toothache
<input type="checkbox"/> Eye pain/strain	<input type="checkbox"/> Ear ringing	<input type="checkbox"/> Snoring	<input type="checkbox"/> TMJ/Jaw problems
<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Earaches	<input type="checkbox"/> Headaches	<input type="checkbox"/> Sore throat
<input type="checkbox"/> Dry eyes	<input type="checkbox"/> Nose bleeds		<input type="checkbox"/> Dry mouth
<input type="checkbox"/> Red & painful eyes	<input type="checkbox"/> Bleeding gums		<input type="checkbox"/> Dry throat
Gastrointestinal & Elimination			
<input type="checkbox"/> Ulcers	<input type="checkbox"/> Hemorrhoids	<input type="checkbox"/> Discomfort after eating	
<input type="checkbox"/> Increased appetite	<input type="checkbox"/> Indigestion	<input type="checkbox"/> Discomfort relieved by eating	
<input type="checkbox"/> Decreased appetite	<input type="checkbox"/> Constipation	<input type="checkbox"/> Gallstones/Gallbladder disease	
<input type="checkbox"/> Nausea/Vomiting	<input type="checkbox"/> Loose stools		
<input type="checkbox"/> Gas	<input type="checkbox"/> Diarrhea	___ # of Bowel movements per day	
<input type="checkbox"/> Abdominal pain	<input type="checkbox"/> Irritable bowel		
<input type="checkbox"/> Liver disease	<input type="checkbox"/> Inflammatory bowel	Please circle type of BM:	
<input type="checkbox"/> Heartburn/ Acid reflux	<input type="checkbox"/> Polyps	loose hard dry soft sticky (sticks to bowl) "normal"	
<input type="checkbox"/> Belching	<input type="checkbox"/> Leaky gut		
<input type="checkbox"/> Rectal bleeding	<input type="checkbox"/> Greasy foods upset	Please circle color of BM:	
	<input type="checkbox"/> Bloating after meals	brown pale color green black bloody	
Cardiovascular & Blood			
<input type="checkbox"/> Irregular heartbeat	<input type="checkbox"/> TIA/Stroke	<input type="checkbox"/> Low blood pressure	<input type="checkbox"/> Swelling of ankles
<input type="checkbox"/> Palpitations/Fluttering	<input type="checkbox"/> Heart murmurs	<input type="checkbox"/> Cold hands/feet	<input type="checkbox"/> Heart disease
<input type="checkbox"/> Chest pain	<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Hands & feet go to sleep easily	<input type="checkbox"/> Heart attack
<input type="checkbox"/> Anemia	<input type="checkbox"/> High LDL cholesterol	<input type="checkbox"/> Chest pressure or tightness	<input type="checkbox"/> Numbness
<input type="checkbox"/> Dizziness	<input type="checkbox"/> Low HDL cholesterol	<input type="checkbox"/> Fast pulse (over 100 beats/min)	<input type="checkbox"/> Varicose veins
	<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Slow pulse (under 60 beats/min)	
Endocrine	Neurological	Respiratory	
<input type="checkbox"/> Thyroid problems	<input type="checkbox"/> Seizures/Epilepsy	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Persistent cough
<input type="checkbox"/> Diabetes Mellitus	<input type="checkbox"/> Nerve pain/inflammation	<input type="checkbox"/> Frequent colds & flu	<input type="checkbox"/> Pleurisy
<input type="checkbox"/> Hypoglycemia	<input type="checkbox"/> Vertigo/Dizziness	<input type="checkbox"/> Wheezing	<input type="checkbox"/> Asthma
<input type="checkbox"/> Feeling hot or cold	<input type="checkbox"/> Paralysis	<input type="checkbox"/> Bronchitis	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Hypo adrenal	<input type="checkbox"/> Numbness/Tingling	<input type="checkbox"/> Shortness of breath	<input type="checkbox"/> Emphysema
	<input type="checkbox"/> Loss of Balance		

Sleep & Energy	Skin	Kidneys & Urinary Tract	Blood Sugar Regulation
<input type="checkbox"/> Insomnia <input type="checkbox"/> Light sleeper/wake easily <input type="checkbox"/> Can't fall back to sleep <input type="checkbox"/> Fatigue <input type="checkbox"/> Tired during day but awake at night <input type="checkbox"/> Can't relax <input type="checkbox"/> Poor memory <input type="checkbox"/> Fuzzy thinking	<input type="checkbox"/> Rashes <input type="checkbox"/> Eczema <input type="checkbox"/> Hives <input type="checkbox"/> Dandruff <input type="checkbox"/> Fungal infections <input type="checkbox"/> Warts <input type="checkbox"/> Psoriasis <input type="checkbox"/> Sweat easily during day <input type="checkbox"/> Sweat easily at night <input type="checkbox"/> Never sweat <input type="checkbox"/> Itchy skin <input type="checkbox"/> Dry skin <input type="checkbox"/> Bruise easily	<input type="checkbox"/> Kidney disease <input type="checkbox"/> Painful urination <input type="checkbox"/> Frequent urinary tract infection <input type="checkbox"/> Frequent urination in general <input type="checkbox"/> Frequent urination at night <input type="checkbox"/> Lack of bladder control <input type="checkbox"/> Kidney stones <input type="checkbox"/> Impaired urination <input type="checkbox"/> Blood in urine	<input type="checkbox"/> Emotional eating <input type="checkbox"/> Excessive appetite <input type="checkbox"/> Hungry between meals <input type="checkbox"/> Irritable before meals <input type="checkbox"/> Get shaky if hungry <input type="checkbox"/> Afternoon headaches <input type="checkbox"/> Crave sweets in afternoon <input type="checkbox"/> Compulsive eating <input type="checkbox"/> Frequent dieting <input type="checkbox"/> Frequent overeating

Women

<input type="checkbox"/> PMS symptoms <input type="checkbox"/> Irregular/missed periods <input type="checkbox"/> Painful periods <input type="checkbox"/> Short cycles (<26 days) <input type="checkbox"/> Long cycles (>35 days) <input type="checkbox"/> Clots in menstrual blood <input type="checkbox"/> Fatigue after menses <input type="checkbox"/> Spotting between periods <input type="checkbox"/> Difficulty conceiving <input type="checkbox"/> Pregnant now _____ Date of last period ___ # Days of bleeding Color of blood: bright dark pale Type of blood: light medium heavy	<input type="checkbox"/> Current or past sexual or physical abuse <input type="checkbox"/> Sexually transmitted disease <input type="checkbox"/> Pain with intercourse Current method of birth control: _____ Past methods of birth control: _____ ___ # of Pregnancies ___ # of Births ___ # of Miscarriages ___ # of Abortions Note any complications during pregnancies, births, postpartum: _____	<input type="checkbox"/> Vaginal discharge <input type="checkbox"/> Vaginal infections <input type="checkbox"/> Breast fibroids <input type="checkbox"/> Breast lumps <input type="checkbox"/> Nipple discharge <input type="checkbox"/> Uterine fibroids <input type="checkbox"/> Endometriosis <input type="checkbox"/> Ovarian Cyst <input type="checkbox"/> Hysterectomy, when: _____ Monthly breast exam? Y N Last Pap Smear: _____ Last mammogram: _____ <input type="checkbox"/> Cancer: ovarian uterine breast cervical <input type="checkbox"/> Menopause symptoms <input type="checkbox"/> Hormone Replacement Therapy <input type="checkbox"/> Decreased sexual energy <input type="checkbox"/> Increased sexual energy
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Men	Musculoskeletal
<input type="checkbox"/> Prostate hypertrophy (BPH) /cancer <input type="checkbox"/> Testicular pain/swelling <input type="checkbox"/> Difficulty conceiving <input type="checkbox"/> Penile discharge <input type="checkbox"/> Increased sexual energy <input type="checkbox"/> Decreased sexual energy <input type="checkbox"/> Sexual difficulties <input type="checkbox"/> Current past sexual or physical abuse <input type="checkbox"/> Sexually transmitted diseases	Note any current joint, muscle, tendon, or ligament problems. Include 1) Cause, 2) Diagnosis, 3) When problem started, 4) Treatment that's helped: _____ _____ _____ _____ _____ Note any past major musculoskeletal problems or injuries: _____ _____ _____