Sarah Taylor, L.Ac., MTCM
509 Olive Way Suite 1258
Seattle, WA 98101
Phone: 206-257-9343

Patient Health History

Name: _____ Date: _____

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

	Condition	For how long?	Past treatment that helped this condition
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:

Event	Date	Event	Date
_____		_____	
_____		_____	
_____		_____	

Family Medical History
(immediate blood relatives)

□ Allergies_____	□ Diabetes	□ Alcoholism
□ Arteriosclerosis	□ Seizures	□ High Blood Pressure
□ Cancer_____	□ Asthma	□ Autoimmune disease_____
□ Heart Disease	□ Stroke	□ Emotional/Psychological Disorder_____
		□ Other_____

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

□ Exercise	□ Coffee	□ Dieting
□ Relaxation/meditation	□ Alcohol	□ Stress
□ Tobacco smoking/chewing	□ Recreational drugs	□ Occupational hazards
		□ Other_____

SYMPTOM LI ST

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

Emotional/Psychological

- □ Anxiety
- □ Depression
- □ Manic
- □ Bipolar
- □ Stress
- □ Frequent irritability
- □ Frequent anger
- □ Mood swings
- □ Anorexia
- □ Bulimia
- □ Frequent Worry
- □ Obsessive/Compulsive
- □ Chronic sadness/grief
- □ Overly fearful
- □ Addictions: (to what?):_____

Immune& Inflammation

- □ Chronic Fatigue Syndrome
- □ Hashimoto's disease
- □ Grave's disease
- □ Arthritis_____
- □ Lupus
- □ Colitis
- □ Crohn's disease
- □ Fibromyalgia
- □ Frequent illness
- □ Frequent infection
- □ Hay fever
- □ Frequent swollen glands
- □ Cancer
- □ Hepatitis A, B or C
- □ Herpes
- □ Chicken pox
- □ HIV
- □ Cold sores
- □ Mononucleosis
- □ Raynaud's Syndrome
- □ Connective tissue inflammation
- □ Food allergies
- □ Environmental allergies
- □ Seasonal allergies

Eyes, Ears, Nose, Throat & Head

- □ Impaired vision
- □ Blurry vision
- □ Eye pain/strain
- □ Glaucoma
- □ Dry eyes
- □ Red & painful eyes
- □ Watery eyes
- □ Impaired hearing
- □ Ear ringing
- □ Earaches
- □ Nose bleeds
- □ Bleeding gums
- □ Runny nose
- □ Sinus problems
- □ Snoring
- □ Headaches
- □ Teeth grinding
- □ Toothache
- □ TMJ/Jaw problems
- □ Sore throat
- □ Dry mouth
- □ Dry throat

Gastrointestinal & Elimination

- □ Ulcers
- □ Increased appetite
- □ Decreased appetite
- □ Nausea/Vomiting
- □ Gas
- □ Abdominal pain
- □ Liver disease
- □ Heartburn/Acid reflux
- □ Belching
- □ Rectal bleeding
- □ Hemorrhoids
- □ Indigestion
- □ Constipation
- □ Loose stools
- □ Diarrhea
- □ Irritable bowel
- □ Inflammatory bowel
- □ Polyps
- □ Leaky gut
- □ Greasy foods upset
- □ Bloating after meals
- □ Discomfort after eating
- □ Discomfort relieved by eating
- □ Gallstones/Gallbladder disease

___# of Bowel movements per day

Please circle type of BM:
loose hard dry soft sticky (sticks to bowl) "normal"

Please circle color of BM:
brown pale color green black bloody

Cardiovascular & Blood

- □ Irregular heartbeat
- □ Palpitations/Fluttering
- □ Chest pain
- □ Anemia
- □ Dizziness
- □ TIA/Stroke
- □ Heart murmurs
- □ Rheumatic Fever
- □ High LDL cholesterol
- □ Low HDL cholesterol
- □ High blood pressure
- □ Low blood pressure
- □ Cold hands/feet
- □ Hands & feet go to sleep easily
- □ Chest pressure or tightness
- □ Fast pulse (over 100 beats/min)
- □ Slow pulse (under 60 beats/min)
- □ Swelling of ankles
- □ Heart disease
- □ Heart attack
- □ Numbness
- □ Varicose veins

Endocrine

- □ Thyroid problems
- □ Diabetes Mellitus
- □ Hypoglycemia
- □ Feeling hot or cold
- □ Hypo adrenal

Neurological

- □ Seizures/Epilepsy
- □ Nerve pain/inflammation
- □ Vertigo/Dizziness
- □ Paralysis
- □ Numbness/Tingling
- □ Loss of Balance

Respiratory

- □ Pneumonia
- □ Frequent colds & flu
- □ Wheezing
- □ Bronchitis
- □ Shortness of breath
- □ Persistent cough
- □ Pleurisy
- □ Asthma
- □ Tuberculosis
- □ Emphysema

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

Women

□ PMS symptoms
□ Irregular/missed periods
□ Painful periods
□ Short cycles (<26 days)
□ Long cycles (>35 days)
□ Clots in menstrual blood
□ Fatigue after menses
□ Spotting between periods
□ Difficulty conceiving
□ Pregnant now

_____ **Date of last period**

___**# Days of bleeding**

Color of blood:
bright dark pale

Type of blood:
light medium heavy

□ Current or past sexual or physical abuse
□ Sexually transmitted disease
□ 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:

_____

□ Vaginal discharge
□ Vaginal infections
□ Breast fibroids
□ Breast lumps
□ Nipple discharge
□ Uterine fibroids
□ Endometriosis
□ Ovarian Cyst
□ Hysterectomy, when: _____

Monthly breast exam? Y N
Last Pap Smear: _____
Last mammogram: _____

□ Cancer: ovarian uterine breast cervical
□ Menopause symptoms
□ Hormone Replacement Therapy
□ Decreased sexual energy
□ Increased sexual energy

Men	Musculoskeletal
□ Prostate hypertrophy (BPH) /cancer □ Testicular pain/swelling □ Difficulty conceiving □ Penile discharge □ Increased sexual energy □ Decreased sexual energy □ Sexual difficulties □ Current past sexual or physical abuse □ 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: _____ _____ _____