East West Medicine  Kim Nguyen L.Ac.

www.EastWestMedicineVA.com

Patient Health History

Name:	Sex:	Age:	Date of Birth:	Date:
Address:	Apt:	City:	State:	Zip Code:
Home Phone #:	Alternate Phone #:	Email:		
Emergency Contact Name:		Emergency Contact Phone #:		
Relationship Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Living w/Partner ☐ Other _____				
Employer:		Occupation:		
Primary Care Physician:		Primary Care Physician Phone #:		
Are you presently under a doctor's care? ☐ Yes ☐ No		With who and for what?		
Are there other therapies which you are involved? ☐ Yes ☐ No		With who and for what?		
Have you been treated by Acupuncture or Chinese Medicine before? ☐ Yes ☐ No		If Yes, When?		
How did you hear of our clinic?				

Health History

Please check any conditions you or your family have had and include the year it began.

	Self	Mother	Father	Sister	Brother	Spouse	Child
Cancer	☐	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐	☐
Hepatitis	☐	☐	☐	☐	☐	☐	☐
Hypertension	☐	☐	☐	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐	☐	☐
Seizures	☐	☐	☐	☐	☐	☐	☐
Thyroid Disorder	☐	☐	☐	☐	☐	☐	☐
Asthma	☐	☐	☐	☐	☐	☐	☐
Pacemaker	☐	☐	☐	☐	☐	☐	☐
Osteoporosis	☐	☐	☐	☐	☐	☐	☐
Herpes	☐	☐	☐	☐	☐	☐	☐
AIDS/HIV	☐	☐	☐	☐	☐	☐	☐
Rheumatic Fever	☐	☐	☐	☐	☐	☐	☐
Alcoholism	☐	☐	☐	☐	☐	☐	☐
Allergies	☐	☐	☐	☐	☐	☐	☐
Mental Illness	☐	☐	☐	☐	☐	☐	☐
Kidney Disease	☐	☐	☐	☐	☐	☐	☐
Anemia	☐	☐	☐	☐	☐	☐	☐
Age at Death	☐	☐	☐	☐	☐	☐	☐

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What is the reason for your visit?

When did this start? _____

How does this problem interfere with daily activties?

☐ Work ☐ Standing ☐ Sitting ☐ Bending ☐ Stretching

☐ Sleep ☐ Walking ☐ Emotional ☐ Recreation ☐ Sexually

☐ Relationships ☐ Social Life ☐ Other _____

Circle the Severity level on a scale from 1-10 (1=no symptoms, 10=worst ever)

1 2 3 4 5 6 7 8 9 10

Please list all injuries, hospitalizations, and surgeries and when they occurred:

Please list any medications, herbs, or supplements that you take regularly (with dosage if applicable):

Are you or may you be currently pregnant? ☐ Yes ☐ No

# of pregnancies _____ # of births _____ premature _____ # of abortions/miscarriages _____

Habits

	Amount/Week?	Year Began	Year Quit
Coffee/Tea			
Soda			
Tobacco			
Alcohol			
Marijuana			
Cocaine/Crack			
Other			

Exercise

Do you exercise regularly? ☐ Yes ☐ No

If so, what type and how often?

Diet

Generally, what do you eat for:

Breakfast _____

Morning Snack _____

Lunch _____

Afternoon Snack _____

Dinner _____

Have you ever had an eating disorder? ☐ Yes ☐ No