Irit D. Weir, L.Ac, M.S.
Lic. #AC3166

Acupuncture Clinic of Napa

(707)226-8724
fax: 226-9470

Confidential Health Inventory

Date:_____

General Information

Email:_____

Name:_____ Age:_____ Birthdate:_____
Last First Middle

Address:_____
Street City State Zip

Mailing Address (if different):_____

Home Phone No._____ Work Phone No._____ SS#_____

Occupation:_____ Employer:_____ Address:_____

Employment Status: ☐ Full-Time ☐ Part-Time ☐ School ☐ Retired ☐ Unemployed ☐ Other:_____

Living Situation: ☐ Alone ☐ Friend(s) ☐ Partner ☐ Spouse ☐ Parents Number of Children:_____

Pets:_____

Status: ☐ Single ☐ Married ☐ Divorce ☐ Widowed

Name of Partner / Spouse / Parent:_____ Occupation:_____
Circle One

Case of Emergency Notify:_____ Phone No._____

How did you hear about the Clinic? _____

Main problem(s) you want to address? _____

_____

How did this condition develop? (What caused it? How did it start?) _____

_____

Have you had this condition or similar condition before? _____

_____

Have you ever received treatment for this condition? ☐ Yes ☐ No

If yes, where? _____

When? _____ By whom? _____

What was the diagnosis? _____

What were the results of treatment? _____

_____

Has this condition been getting ☐ Better ☐ Worse ☐ Staying the same?

What do you think is wrong? _____

_____

Other problems you would like to address_____

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Please check the following symptoms which you have had in the past or are experiencing currently:

Head & Face
- ☐ Headaches
- ☐ Dizziness
- ☐ Memory Loss
- ☐ Neck Lump/Swelling
- ☐ Other:_____

Eyes
- ☐ Blurred Vision
- ☐ Eyelid Problem
- ☐ Dry/Itchy Eyes
- ☐ Pain
- ☐ Other:_____

Ears
- ☐ Poor Hearing
- ☐ Earaches
- ☐ Discharges
- ☐ Ringing
- ☐ Other:_____

Nose
- ☐ Frequent Colds
- ☐ Sinus Trouble
- ☐ Nose Bleeds
- ☐ Nasal Obstruction
- ☐ Other:_____

Mouth
- ☐ Gum Problem
- ☐ Teeth Problem
- ☐ Memory Loss
- ☐ Tongue Problem
- ☐ Lip Problem
- ☐ Jaw Problem
- ☐ Unusual Tastes
- ☐ Other:_____

Throat
- ☐ Sore Throat
- ☐ Swollen Glands
- ☐ Hoarseness
- ☐ Difficulty Swallowing
- ☐ Other:_____

Respiratory
- ☐ Difficulty Breathing
- ☐ Pain
- ☐ Chronic Fever
- ☐ Cough
- ☐ Cough Up Phlegm
- ☐ Cough Up Blood
- ☐ Chest Colds
- ☐ Weezing
- ☐ Other:_____

Heart & Thorax
- ☐ Palpitations
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Tightness in Chest
- ☐ Difficulty Lying Flat
- ☐ Chest Pains
- ☐ Other:_____

Circulation
- ☐ Bruise Easily
- ☐ Bleed Easily
- ☐ Leg Cramps
- ☐ Cold Limbs
- ☐ Swollen Feet/Ankles
- ☐ Other:_____

Gastro-Intestinal
- ☐ Weight Loss
- ☐ Belching
- ☐ Excessive Thirst
- ☐ Never Thirsty
- ☐ Excessive Hunger
- ☐ Lack of Appetite
- ☐ Stomach Bloating
- ☐ Nausea/Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Heartburn
- ☐ Difficult Digestion
- ☐ Stomach Pain
- ☐ Colon Problem
- ☐ Hemorrhoids
- ☐ Other:_____

Urination
- ☐ Frequent
- ☐ Difficulty Starting
- ☐ Painful/Burning
- ☐ Night Frequency
- ☐ Blood in Urine
- ☐ Bed Wetting
- ☐ Other:_____

Skin
- ☐ Rashes
- ☐ Dryness/Itching
- ☐ Moles/Lumps That Change
- ☐ Excess Sweat
- ☐ Night Sweat
- ☐ Rarely Sweat
- ☐ Acnes/Boils
- ☐ Other:_____

Neurological
- ☐ Nervousness
- ☐ Fainting
- ☐ Tremors
- ☐ Convulsions
- ☐ Numb or Tingling Limbs
- ☐ Poor Coordination
- ☐ Nerve Pain or Neuralgia
- ☐ Other:_____

Sleep
- ☐ Excessive
- ☐ Insomnia
- ☐ Drowsiness
- ☐ Excess Dreams
- ☐ Other:_____

Moods
- ☐ Annoyed by Little Things
- ☐ Work or Family Problems
- ☐ Cry Often
- ☐ Anger
- ☐ Lack of Concentration
- ☐ Difficulty Making Decisions
- ☐ Anxious/Tense
- ☐ Depression
- ☐ Suicidal
- ☐ Loss of Sexual Drive
- ☐ Shy or Sensitive
- ☐ Other:_____

General

Have you ever had acupuncture or taken chinese herbs before? ☐ Yes ☐ No

What is the most important health change you would like to have occur?_____

_____

_____

_____

Men Only

☐ Weak Urine Stream_____ ☐ Burning or Discharge_____ ☐ Impotence_____

☐ Prostate Problems_____ ☐ Painful Testicles_____ ☐ Other:_____

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Current Medical Status

General Health: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Medications (vitamins, prescription or otherwise):_____

_____

Have you ever had your cholesterol level checked?_____ Date(s):_____ Results:_____

Allergies

Drug Allergies (penicillin, etc.):_____

Type of reaction:_____

Allergies to food, pollens, etc.:_____

Type of reaction:_____

Current/Recent Health Care Providers

Name Dates Care Provided

_____

_____

_____

Do any health care providers request follow-up visit here?_____ If yes, name:_____

_____

Date of last physical:_____

Past Medical History

Dates Hospital Diagnosis / Operation Doctor

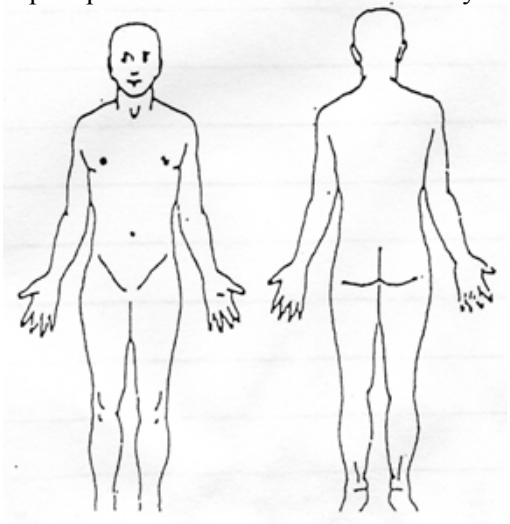
_____

_____

_____

Anything unusual about your birth?_____

If you are in pain please mark the exact location of your pain below:



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Please check the following conditions you have had in the past:

☐ Alcoholism	☐ Emphysema	☐ Hypoglycemia	☐ Pneumonia
☐ Anemia	☐ Eating disorders	☐ Bleeding tendency	☐ Rheumatic fever
☐ ARC/AIDS	☐ Epilepsy	☐ Kidney stones / disease	☐ Scarlet fever
☐ Arteriosclerosis	☐ Gall stones	☐ Liver disease	☐ Stroke
☐ Arthritis	☐ Glaucoma	☐ Lumbago	☐ Thyroid disease
☐ Asthma	☐ Goiter	☐ Malaria	☐ Tuberculosis
☐ Auto accident	☐ Gout	☐ Measles	☐ Tumor
☐ Cancer	☐ Heart disease	☐ Migraine HA	☐ Ulcers
☐ Cold sores	☐ Hepatitis	☐ Mononucleosis	☐ Varicose veins
☐ Diabetes	☐ Hernia	☐ Osteoporosis	☐ Venereal disease
☐ Blood transfusion	☐ High cholesterol	☐ Parasites	☐ Whooping cough
☐ Other	☐ Hives	☐ Pleurisy	

Habits

Dietary preferences/restrictions:_____

Sample of day's menu:

Breakfast: _____

Lunch: _____

Dinner: _____

☐ Tobacco _____ #/Day

☐ Alcohol _____ Drinks/Day

☐ Drugs _____

☐ Caffeine _____ Cups/Day

☐ Water _____ Glasses/Day

☐ Sleep _____ Hours/Night

☐ Exercise _____ Times/Week

Stresses

Stresses (family, work, self, etc.)_____

_____

Family History

Member	Living?	Age?	Important Diseases *(see below)* *Alcoholism, High Blood Pressure, Cancer, Diabetes Heart Disease, Osteoporosis and other addictions, other illnesses*	Cause of Death & Age
Mother				
Father				
Sisters(s)				
Brother (s)				
Maternal Grandmother				
Paternal Grandmother				
Maternal Grandfather				
Paternal Grandfather				
Paternal Aunt(s)				
Maternal Aunt(s)				

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Women Only

Date last period began: _____ Date of last pelvic exam: _____

Date prior period began: _____ Date of last Pap smear: _____

Age of first period: _____ Were the above normal? _____

Have you ever had an abnormal Pap? _____When: _____ Results: _____

Treatment: _____

_____

Are you sexually active? _____ Do you have intercourse? _____ Do you practice safe sex? _____

Are you trying to get pregnant? _____ How long? _____

Current birth control method? _____ How long? _____

Problems with it: _____

_____

Past birth control methods: _____

Normal (not on pills), the number of days from the start of one period to the start of the next: _____

Number of days of flow: _____

Amount of bleeding: _____ Amount of cramps: _____

Premenstrual symptoms: _____

Starting when? _____

Any current changes in your normal pattern? _____

Any bleeding between periods? _____ When? _____

Any unusual pelvic pain, pressure, or fullness? _____ When? Describe: _____

Any unusual vaginal discharge or itching? _____ Describe: _____

How long? _____ Past treatment: _____

Any sexual concerns to discuss? _____

Any past history of tubal infection? _____

Any past history of sexually transmitted disease? _____

Any history of DES exposure? (DES was a drug taken by mothers during pregnancy to prevent miscarriage) _____

_____

Other: _____

_____

Pregnancies: (Including miscarriages and abortions)

Dates	How far along	Sex	Weight	Problems