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

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The Acupuncture Clinic Of Napa

Confidential Health Inventory
General Information

Date:_____

Email:_____

Name:_____ Preferred Pronuns:_____
First *Middle* *Last*

Age:_____ Birthdate:_____ SS#_____

Address:_____
Street *City* *State* *Zip*

Mailing Address (*if different*):_____

Home phone No._____ Work phone No._____

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 ☐ Divorced ☐ Widowed

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

Emergency contact:_____ 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 ever received treatment for this condition? ☐ Yes ☐ No

If yes, where? _____

When?_____ By whom?_____

What was the diagnosis? _____

What were the results of the 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
☐ Neck lump or swelling
☐ other: _____

Eyes
☐Blurred Vision
☐Eyelid Problems
☐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
☐Difficulty Swallowing
☐ Other:_____

Respiratory
☐Difficulty Breathing
☐Pain
☐Chronic Fever
☐Cough
☐Cough up Phlegm
☐Cough up Blood
☐Chest Colds
☐Wheezing
☐Other:_____

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

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

Gastro-Intestinal
☐ Weight loss
☐Belching
☐Never Thirsty
☐Excessive Hunger
☐Lack of Appetite
☐Stomach Bloating
☐Nausea/Vomiting
☐Diarrhea
☐constipation
☐Heartburn
☐Difficult Digestion
☐Stomach Pain
☐Colon Problems
☐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
☐Acne/Boils
☐Other:_____

Neurological
☐Nervousness
☐Fainting
☐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
☐Loss of Sexual Drive
☐Shy or Sensative
☐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, prescriptions, or Otherwise):_____

_____

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:_____

_____

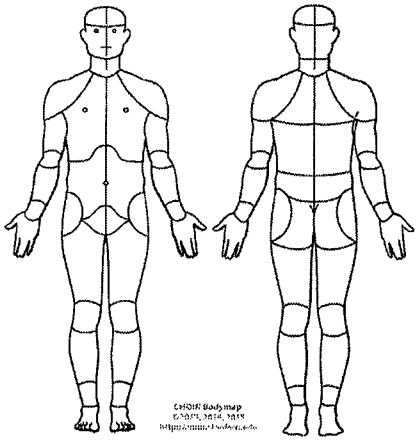
Date of last physical:_____

Past Medical History

Dates	Hospital	Diagnosis/Operation	Doctor

Anything unusual about your birth?_____

If you are I 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	☐ Migraine HA	☐ Tumor
☐ Cancer	☐ Heart disease	☐ Measles	☐ Ulcers
☐ Cold sores	☐ Hepatitis	☐ Mononucleosis	☐ Varicose Veins
☐ Diabetes	☐ Hernia	☐ Osteoporosis	☐ Venereal disease
☐ Blood transfusion	☐ High Cholestrol	☐ 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 _____

☐ Water _____ Glasses/Day

☐ Sleep _____Hours/Night

☐ Exercise _____Times/Week

Stresses

Stresses (Family, Work, Self, etc.) _____

_____

Family History

Important Diseases (*see below*)

Alcoholism, High Blood Pressure, Cancer, Diabetes,
Heart Disease, Osteoporosis, and other addictions, other illnesses

Member	Living?	Age?	Cause of Death & Age
Mother			
Father			
Sister(s)			
Brother(s)			
Maternal Grandmother			
Paternal Grandmother			
Maternal Grandfather			
Paternal Grandfather			
Maternal Aunt(s)/Uncle(s)			
Paternal Aunt(s)/Uncle(s)			

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Woman 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:_____
The number of days from the start of one period to the start of the next (not on pills):_____
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 to prevent miscarriages):
_____

Other:_____

Pregnancies: (Including miscarriages and abortions)

Dates	How far along	sex	weight	problem