Alliance Wellness Center Inc./ Bend Community Acupuncture
740 NW Colorado Ave. Bend, OR 97701
Phone 541 388-4822 Fax 541 388-4805

CONFIDENTIAL HEALTH HISTORY

Name____

Date ____________________

What is (are) your MAIN concern(s)? Please describe briefly and indicate date symptom(s) first appeared:

1. ____
2. ____
3. ____

Is your condition due to injury or sickness arising from employment? Yes _____ No _____

Is your condition due to injury from an auto accident? Yes _____ No _____

Have you ever had the same or similar condition? Yes _____ No _____

If Yes, when and describe: ____

____

____

Are you being treated elsewhere for this condition? Yes _____ No _____

If 'yes', what are the name(s) of other health care providers who are treating you:

____

____

MEDICAL HISTORY

Date of Birth_____________ Age_____ Height________ Weight_________ Blood Pressure____________
(If known)

Are you currently under a doctors care? Y N If yes, please explain________________________________

____

Date of last physical exam______________________ By whom___________________________________

Please list any medications/ drugs/ vitamins/ supplements/ herbs you are currently tak-
ing:____

____

____

____

Please list any surgeries (including dates) that you have had:

____

____

____

____

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CONFIDENTIAL PATIENT INFORMATION / MEDICAL HISTORY CONTINUED…..

Please check the conditions that are now or have been a part of your health history by placing either a:
P=Previously or a **C=Currently**

__ __heart disease	__ __fainting / dizziness	__ __poor sleep	__ __thyroid disease
__ __high blood pressure	__ __ulcers	__ __arthritis	__ __menstrual problems
__ __migraines	__ __allergies	__ __bruising	__ __emotional problems
__ __diabetes	__ __rashes	__ __earaches	__ __seizures
__ __pacemaker	__ __neck/back pain	__ __eye problem	__ __fatigue
__ __HIV+	__ __high cholesterol	__ __constipation	__ __cancer
__ __hepatitis	__ __eczema / psoriasis	__ __diarrhea	__ __anxiety disorder
__ __herpes	__ __joint pain	__ __hypoglycemia	__ __pituitary disorder
__ __pregnancy	__ __asthma	__ __night sweats	__ __digestive problems

Is there anything else significant in your health history? ____

____

____

____

Family History

Has any member of your family had any of these conditions? (place letter by all that apply)

a. asthma	mother_____________
b. cancer	father____________
c. diabetes	brother___________
d. seizures	sister___________
e. heart disease	maternal grandmother_________
f. high blood pressure	maternal grandfather__________
g. stroke	paternal grandmother_________
h. alcoholism	paternal grandfather__________
i. high cholesterol	

j. other (please list)____

____

Lifestyle

What is your daily consumption of water (glasses per day)? _______
How many hours of sleep do you average per night?__________
How many hours and days do you work per week? __________
Which of the following is part of your lifestyle (please check)?

	How much/often?
__ Cigarettes	___________________
__ Coffee	___________________
__ Soda	___________________
__ Tea	___________________
__ Alcohol	___________________
__ Recreational drugs	___________________
__ Special / restricted diet	___________________
__ Exercise	___________________
__ Other	___________________

Which of the following statements best describes you?

____I am a relaxed, mellow type of person who takes things as they come.

____I am a high energy person, and I have a tendency to make things happen.

____I am a combination of the two. statements above.