DENISE L. STEVENS, LAc
Traditional Asian Medicine For Modern Health

PATIENT CONFIDENTIAL INFORMATION

Date: _____

Patient Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____

Email Address: _____

Age: _____ Date of Birth: _____ Sex: M / F

Marital Status: S M D Cohab W

Place of Birth: _____

SS#: _____

Occupation or Profession: _____

Employer: _____

Emergency Contact Information

Emergency Contact: _____

Relation: _____ Phone: _____

Referral Source: _____

Patient Medical History - All Information is Kept Strictly Confidential

Name: _____ Date: _____/_____/_____
(first) (middle) (last)

Date of Birth: _____/_____/_____ Age: _____ Gender: M / F Marital status: S M D W

Successful health care and preventative medicine are only possible when the practitioner has a complete understanding of the patient physically, mentally and emotionally. Please complete this questionnaire as thoroughly as possible. Print all information and indicate areas of confusion with a question mark. Thank you.

1. When and where did you last receive health care? _____

For what reason? _____

2. Has your case been referred to an attorney? Y N

3. Please identify below the health concerns that have brought you here, in order of importance:

Condition **Past Treatment**

a. _____ _____

How does this condition affect you? _____

b. _____ _____

How does this condition affect you? _____

c. _____ _____

How does this condition affect you? _____

d. _____ _____

How does this condition affect you? _____

4. If applicable, please list any foods, drugs, or medications you are hypersensitive or allergic to (please include reaction):

_____

_____

5. Please list all medications (prescribed and over-the-counter), vitamins, and supplements you are currently taking:

_____

_____

_____

6. Do you have any reason to believe you may be pregnant? Y N

If so, how far along are you? _____

7. Do you have any infectious diseases? Y N If yes, please identify: _____

8. **Family History:** Father Mother Brothers Sisters Spouse Children

Check those applicable:

Age (if living)	_____	_____	_____	_____	_____	_____
Health (G=Good, P=Poor)	_____	_____	_____	_____	_____	_____
Cancer	_____	_____	_____	_____	_____	_____
Diabetes	_____	_____	_____	_____	_____	_____
Heart Disease	_____	_____	_____	_____	_____	_____
High Blood Pressure	_____	_____	_____	_____	_____	_____
Stroke	_____	_____	_____	_____	_____	_____
Mental Illness	_____	_____	_____	_____	_____	_____
Asthma/Hay fever/Hives	_____	_____	_____	_____	_____	_____
Rheumatoid Arthritis	_____	_____	_____	_____	_____	_____
Kidney Disease	_____	_____	_____	_____	_____	_____
Age (at death)	_____	_____	_____	_____	_____	_____
Cause of Death	_____	_____	_____	_____	_____	_____

9. **Height:** _____ **Weight:** Currently: _____ Past Maximum: _____ When? _____

10. **Blood Pressure:** What is your most recent blood pressure reading? _____/_____ When was this reading taken? _____

11. **Childhood Illness** (please circle any that you have had):

Scarlet Fever Diphtheria Rheumatic Fever Mumps Measles German Measles Chicken Pox

12. **Immunizations** (please circle any that you have had):

Polio Tetanus Rubella/Mumps/Rubella Pertussis Diphtheria Hib Hepatitis B

Others: _____

13. **Hospitalizations and Surgeries:**

Reason	When	Reason	When
_____		_____	
_____		_____	
_____		_____	

14. **X-Rays/CAT Scans/MRI's/NMR's/Special Studies:**

Reason	When	Reason	When
_____		_____	
_____		_____	
_____		_____	

15. **Emotional** (please circle any that you experience now and underline any that you have experienced in the past):

Mood Swings | Nervousness/Anxiety | Mental Tension | Depression | Sadness

Angry/Frustrated Often | Chronic Worry | Chronic Fear | Panic Attacks

16. **Energy and Immunity** (please circle any that you experience now and underline any that you have experienced in the past):

Fatigue | Slow Wound Healing | Chronic Infections | Chronic Fatigue Syndrome

Epstein Barr Virus (EBV) | Frequent Colds/Flu: # ___ times per year

17. **Head, Eye, Ear, Nose, and Throat** (please circle any that you experience now and underline any that you have experienced in the past):

Impaired Vision | Eye Pain/Strain | Glaucoma | Caataracts | Glasses/Contacts | Tearing/Dryness

Impaired Hearing | Ear Ringing | Earaches | Headaches | Sinus Problems | Nose Bleeds

Frequent Sore Throats | Hoarseness | Teeth Grinding | TMJ/Jaw Problems

Cold Sores | Hay Fever | Difficulty Swallowing | Other:_____

18. **Respiratory** (please circle any that you experience now and underline any that you have experienced in the past):

Pneumonia | Frequent Common Colds | Difficulty Breathing | Emphysema

Persistent Cough | Pleurisy | Asthma | Tuberculosis

Shortness of Breath | Other Respiratory Problems: _____

19. **Cardiovascular** (please circle any that you experience now and underline any that you have experienced in the past):

Heart Disease | Coronary Artery Disease | Chest Pain | Swelling of Ankles | High Blood Pressure

Palpitations/Fluttering | Stroke | Heart Murmurs | Rheumatic Fever | Varicose Veins | Vasculitis

Cardiac Pacemaker | Cardiac Defibrillator Implant | Other:_____

20. **Gastrointestinal** (please circle any that you experience now and underline any that you have experienced in the past):

Ulcers | Changes in Appetite | Nausea/Vomiting | Epigastric Pain | Passing Gas | Heartburn

Belching | Gall Bladder Disease | Liver Disease | Hepatitis B or C | Hemorrhoids | Abdominal Pain

Pancreatitis | Changes in Bowel Habits | Constipation | Diarrhea | Other:_____

21. **Genito-Urinary Tract** (please circle any that you experience now and underline any that you have experienced in the past):

Kidney Disease | Painful Urination | Frequent UTI | Frequent Urination | Heavy Flow

Kidney Stones | Impaired Urination | Blood in Urine | Frequent Urination at Night

22. **Female Reproductive/Breasts** (please circle any that you experience now and underline any that you have experienced in the past):

Irregular Cycles | Breast Lumps/Tenderness | Nipple Discharge | Heavy Flow

Vaginal Discharge | Premenstrual Problems | Clotting | Bleeding Between Cycles

Menopausal Symptoms | Difficulty Conceiving | Painful Periods | Ovarian or Cervical Disease

23. **Skin:** (please circle any that you experience now and underline any that you have experienced in the past)

Eczema Psoriasis Acne Obvious Changes in a Wart or Mole

Rashes Hives Contact Dermatitis Sores that Will Not Heal

23. **Menstrual/Birthing History:**

1. Age of First Menses: _____ 4. Birth Control Type: _____ 7. # of Abortions: _____

2. # of Days of Menses: _____ 5. # of Pregnancies: _____ 8. # of Live Births: _____

3. Length of Cycle: _____ 6. # of Miscarriages: _____ 9. Date of Last Menses:_____

24. **Male Reproductive** (please circle any that you experience now and underline any that you have experienced in the past):

Sexual Difficulties Prostrate Problems Testicular Pain/Swelling Penile Discharge

25. **Musculoskeletal** (please circle any that you experience now and underline any that you have experienced in the past):

Neck/Shoulder Pain Muscle Spasms/Cramps Arm Pain Upper Back Pain Mid Back Pain

Low Back Pain Leg Pain Joint Pain (if so, where?): _____

Fibromyalgia

26. **Neurologic** (please circle any that you experience now and underline any that you have experienced in the past):

Vertigo/Dizziness Paralysis Numbness/Tingling Loss of Balance Seizures/Epilepsy

27. **Endocrine** (please circle any that you experience now and underline any that you have experienced in the past):

Hypothyroid Hypoglycemia Hyperthyroid Diabetes Mellitus Diabetes Insipidus

Night Sweats Feeling Hot or Cold

28. **Other** (please circle any that you experience now and underline any that you have experienced in the past):

Anemia Cancer Rashes Eczema/Hives Cold Hands/Feet

Bleeding Disorder Jaundice Hernia Sexually Transmitted Diseases:_____

Unusual Bleeding or Discharge:_____ Ulcerative Colitis Crohn's Disease

Irritable Bowel Disease Lupus Erythematosus Rheumatoid Arthritis HIV/AIDS

Is there anything else we should know? _____

_____

_____

_____

_____

29. **Lifestyle:**

a. Do you typically eat at least three meals per day? Y N If no, how many? _____

b. Do you follow a special diet (vegan, vegetarian, pescatarian, high protein, kosher, etc.): Y N

If so, please describe:_____

_____

c. Do you have any food allergies? Y N

List all food allergies:_____

_____

d. Describe a typical day's meals, including beverages:

Breakfast:

Lunch:

Dinner:

Snacks:

e. Exercise routine: _____

f. Spiritual practice: _____

g. How many hours per night do you sleep? _____ Do you wake rested? Y N

h. Level of education completed: High School Bachelors Masters Doctorate Other

i. Occupation: _____ Employer: _____ Hours/Week: _____

Do you enjoy work? Y/N Why/Why not? _____

j. Nicotine/Alcohol Use: _____

k. Do you drink carbonated beverages/sodas? Y N If so, how many daily: _____

l. Have you experienced any major traumas? Y N Explain: _____

_____

m. Television habits: _____ Reading habits: _____

n. Interests and hobbies: _____