Kathryn McCarthy L.Ac., LLC

at Healing Chiropractic 9901 NE 7th Ave B-110 Vancouver, WA 98685 360-326-6988

Patient Health History

Name: ____ Date: ______/______/______

Address ____ City ____________________State _____Zip ____________________

Home phone__________________________ Work phone ______________________ Occupation ________________________

Emergency Contact: Name:________________________________Relationship _________________Phone: _________________

Date of Birth: _______/_______/_______ Age: _______ Ht _____ Wt: ______ Gender: M/F Marital status: S M/P D W

Email : ___________________________________ Cell phone ______________ Referred By ___________________________

1. Do you have Health Insurance (Name) _______________________________ Does it cover acupuncture _________________

Authorization for payment: I authorize the release of any medical or other information necessary to process insurance claims. I authorize payment of medical benefits to the provider herein for services and treatment by me

Is this related to an auto accident? Yes _______ No _________ If yes, in what State did it occur and date _____________________Date _________

Signature ____Date : _______________________________________-

2. Are you under the care of a physician now Yes _________ No _______________

For what reason? ____

Have you had acupuncture in the past _______________________________

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

Condition:. ____How does this condition affect you? ______________________

What makes it worst ____________________________What makes it better _____________________________

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

____

5. Please list any 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 yes, how far along __________

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

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

Scarlet Fever Diphtheria Rheumatic Fever Mumps Measles German Measles Chicken Pox

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

Polio Tetanus Rubella/Mumps/Rubella Pertussis Diphtheria Hepatitis B

Others: ____

10 **Surgeries/ MRI's /Xrays/CAT scans:**

Reason When Reason When

_____________________________________ ______________________________________

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11. **Family History:**

Check those applicable:

	Father	Mother	Brothers	Sisters	Children	Self
Age (if living)	_______	________	________	________	________	_______
Health (G=Good, P=Poor)	_______	________	________	________	________	_______
Cancer	_______	________	________	________	________	_______
Diabetes	_______	________	________	________	________	_______
Heart Disease	_______	________	________	________	________	_______
High Blood Pressure	_______	________	________	________	________	_______
Stroke	_______	________	________	________	________	_______
Mental Illness	_______	________	________	________	________	_______
Asthma/Hay fever/Hives	_______	________	________	________	________	_______
Kidney Disease	_______	________	________	________	________	_______
Seizure	_______	________	________	________	________	_______
Any other Dx	_______	________	________	________	________	_______
Age (at death)	_______	________	________	________	________	_______
Cause of Death	_______	________	________	________	________	_______

12. **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?): _________________________

13. **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

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

Hypothyroid Hypoglycemia Hyperthyroid Diabetes Mellitus Night Sweats Feeling Hot or Cold

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

Mood Swings Nervousness Mental Tension

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

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 Glasses/Contacts Tearing/Dryness

Impaired Hearing Ear Ringing Earaches Headaches Sinus Problems

Nose Bleeds Frequent Sore Throats Teeth Grinding TMJ/Jaw Problems Hay Fever

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: ____

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

Heart Disease Chest Pain Swelling of Ankles High Blood Pressure

Palpitations/Fluttering Stroke Heart Murmurs Rheumatic Fever Varicose Veins

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

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

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: ________ Age of Menopause ___________

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. **Miscellaneous :** Is there any thing else we should know about____

26. **Your Diet:** (circle all that apply)

Appetite: High/Low Coffee/ Soft Drinks Artificial sweeter Sugar cravings/ salty cravings glasses of water/day _____________

27. Average Daily Menu

Morning Snack Noon Snack Evening Snack

____

____

____