BLISS HEALING

Health History Questionnaire

Name____ DOB ________ Age____yrs. Date ________________

Height _______ Weight_____lbs. How did you learn of BLISS HEALING? ____________________ First acupuncture? Y N

*** Please help me to help you by taking time to complete this form thoroughly and accurately. All of your answers will remain confidential.** It is best if you return it a few days before our visit so that I may read it in advance and begin considering your case.

Address ____ City, State, Zip ____________________________________

Email ____ **Phone #**(s) ____

Emergency contact: ______________________________ Relation to you? _____________ Phone #s_______________

Primary Care Provider's (PCP) Name and Contact Info. ____

Occupation? (or student or retired) __________________________ Where? _____________________________________

Are you ☐Partnered/married ☐Single ☐Separated/divorced ☐Widowed. Are you ☐Male ☐Female ☐Trans ☐Other_______

Are you a veteran? ☐Yes ☐No Are you on disability? ☐Yes ☐No. If yes, for how long? _____

Main Health Concern - Briefly state your main health concern(s) that you'd like me to address.

1 ____ When & how did it start?_____________________________

Have you been given a diagnosis for this complaint? __________________________If so, by whom? _____________

2 ____ When & how did it start?_____________________________

Have you been given a diagnosis for this complaint? __________________________If so, by whom? ______________

What have you done for it/them? (Check all that apply) ☐MD ☐Naturopath (ND), ☐Chiropractic(DC) ☐Acupuncture ☐Physical Therapy(PT) ☐Homeopathy ☐Nutritionist ☐Massage ☐Reiki ☐Other? ____

*Metal and/or latex allergy? Y N **Other Allergies** (Please list) ____

Medical History Check/complete all that apply. **If it is within the last 4 months, please add a star next to it.**

☐Bleeding disorders (Check) _Hemophilia, __von Willebrand's, __Blood thinning meds., __Other ______________ ☐Hepatitis ___

☐GI Concerns ________________	☐Excessive appetite or cravings	☐Diabetes	☐Weight gain
☐Weight Loss-Intended? Unintended?	☐Weekly laxative use	☐Acid reflex/GERD	☐Hemorrhoids
☐Lyme or other tick-borne illness	☐Anxiety	☐Drug or Alcohol Over-use	☐Cold Sores
☐Loose Stools, more than 3/day	☐Red Blood in stools	☐Black, "tar-like" stools	☐Eating Disorder(s)
☐Dental Concerns ________________	☐IBS/Crohn's/Ulcerative colitis	☐ Bleeding gums	☐Jaw pain
☐Heart Concerns ________________	☐Palpitations/Heart flutters	☐Pacemaker	☐Chest pain
☐Easy bleeding or bruising	☐Spontaneous nosebleeds	☐High Blood pressure	☐Low Blood pressure
☐Stroke, When? ________________	☐Irregular heartbeat	☐Varicose / spider veins	☐Fatigue
☐Concussion/Brain Injury, year? _____	☐Dizziness or Fainting	☐Headaches / ☐Migraines	☐ADD/ADHD
☐Mental Health Concerns___________	☐Worsening or Blurred vision	☐Suicidal thoughts	☐Seizures ☐Tremor
☐Trouble falling asleep	☐Trouble staying asleep	☐Night sweats	☐Depression
☐Hyperthyroid / ☐Hypothyroid	☐Hearing Loss	☐Ringing in ears	☐Tuberculosis (TB)
☐Respiratory Issues _______________	☐Frequent colds	☐Asthma	☐Marfan's Disease
☐Phlegm… Color ________________	☐Unexplained Shortness of breath	☐Sweating easily/spontaneously	☐Cold feet or hands
☐Auto-immune Disorder ___________	☐Decreased Urine Flow/Dribbling	☐Kidney/ Urinary Disorder	☐Blood in urine
☐Cancer, where? __________________	☐Skin problems_______________	☐Swollen feet or hands	☐Incontinence
☐Sexually transmitted infection	☐Impotence	☐High Libido	☐Low Libido
☐Carpal Tunnel Syndrome	☐Numbness in 1 or more limbs	☐Muscle weakness	☐Tendonitis
☐Arthritis Where? _________________	☐Reduced Coordination/balance	☐Knee Problems	☐Ankle concerns
☐Replaced joint(s) Which? __________	☐Shoulder concerns	☐Hip problems ☐Sciatica	☐Back Pain ☐Neck Pain

Other health concerns that were not listed? ____

Which health concerns, if any, tend to occur in your family of origin? ____

Are you sexually active? ☐Yes ☐No

Could you be pregnant? ☐Likely ☐Maybe ☐Unlikely Do you want to have kids soon? ☐Yes ☐No

Hospitalizations / Surgeries / Significant Traumas (Include dates) ____

____ ____

____ ____

How many times do you wake to urinate at night? ____ Are you able to fall back to sleep easily afterward? Yes No

Do you have a regular exercise routine? Yes No If yes, describe ____

____

Do you engage in repetitive motions (typing, etc.) regularly? If so, please describe. ______________________________

Medications Data

Medication, Supplement, Herb	Dosage	Recommended by	Reason for Taking	Length of Usage

(Check which is true for you.) I received the standard more than the standard less than the standard number of vaccinations at the recommended schedule when I was young.

Approximately how many times have you taken antibiotics in your life? 1-10 11-20 21-50 More than 50.

Have you taken hypertension medications at any point in your life? Yes No If so, from when to when? _________

Comments on other medication use and/or your medication use in general: ____________________________________

____

If you smoke (including vaping), how many per day? __ Which? __________ Recreational drug use? Which? _________

- -

*** This section is for women only…** (Please answer menstrual questions even if you are post-menopausal. Thanks)

Age of first period ______ Typical # of days of bleeding ______ Typical number of days between cycles _____

(Check which apply) Heavy Scanty Dark blood Thin blood Bright red blood Tiny clots Large clots Cramps

Bloating Irritable Sad Weepy Other cycle-related symptoms? ____

Number of pregnancies ___ Live births ___ Premature births"aaa "Date of last PAP________________

Which birth control do you use _____________________ For how long? ___________ Previous birth control types ___________

Vaginal discharge Uterine fibroids Ovarian cysts PCOS Breast lumps Other female concerns?_______________

*** This section is for men only…**

Recurrent jock itch Issues with getting/maintaining an erection pm ejaculation separate from sex Painful ejaculation

Symptoms (dizziness, back weakness, etc.) after ejaculation"aaaaaa Other male concerns?______________________________

- -

Diet (Check) Vegetarian, Gluten-free, Lactose-free, Paleo, Other_____________ For how long? ____________

Foods/flavors you crave? _________________________

How many 8oz. servings of per day - caffeinated beverages?___, carbonated drinks?___, water/clear unsweetened tea? ___

How many alcoholic beverages do you drink each week? ____

Typical Food Choices Describe a typical day (or blend of days) of dietary intake including foods and beverages.

Morning ____

Afternoon ____

Evening____

Night____

Is there anything else that I should know or you'd like to discuss that wasn't touched upon in this form?

____

Thank you. I look forward to working with you to regain and maintain your optimal health and vitality.

/"Uw| cppc"Drkuu."O Gf ."O Ce."NCe."F krnCe."Lcrcpgug"("Qtvj qrgfke"Cewrwpewtkuv."Y guvgtp"J gtdcrkuv."Pwtkkqpkuv"