Five Seasons Healthcare Confidential Health Inventory

Today's Date _____

Name_____ Cell _____ Work _____

Address _____ Home _____

City, State, Zip _____ Height _____ Weight_____ Birthdate _____

Email: _____ Would you like email health updates: _____

Do you live: Alone_____ Friend(s) _____ Partner _____ Spouse_____ Mother _____ Father _____ Siblings _____

Ages of children living with you:_____ Single___ Married ____ Divorced___ Widowed_____

Pets _____

Occupation_____ Full ____ Part time ____ School ____ Retired ____ Other_____

Occupational Stresses (chemical, physical, psychological) and number of hours you work during the week_____

_____

In case of emergency contact:_____

How did you hear about us? _____

What are your health concerns? _____

_

_____

_____

Reason for today's visit _____

_____

What kind of treatment have you tried _____

Have you experienced acupuncture before _____

Family History: Please place an X in the appropriate box. Note the age of onset. If you don't know the history, place a hyphen (--)

Allergies	Self	Grandmother	Grandfather	Mother	Father	Sister	Brother	Spouse	child
Blood disorder/anemia									
Diabetes									
Cancer or tumors									
Seizures									
High blood pressure									
High cholesterol									
Kidney or bladder disorder									
Drug abuse									
Alcoholism									
Tuberculosis									
Stroke or heart disease									
Depression/mental illness									
HIV									
Hepatitis									
Other									
Age of death									
Auto-immune disorders									
Thyroid problems									
Arthritis									
Parasites									

CURRENT MEDICATIONS (heart, thyroid, aspirin, HRT, anti-inflammatories, anti-acids, antibiotics, etc)

Name	Dose	Time of day it's taken	Date started	Have you experienced any side effects?

ALLERGIES TO MEDICATIONS, SUPPLEMENTS, FOOD, ENVIRONMENTAL

Medications/supplements				
Food or environmental				

VITAMIN, HERB, AND FOOD SUPPLEMENTS

Supplements	Dose	How often	How long	Supplements	Dose	How often	How Long

CURRENT OR RECENT HEALTH CARE PROVIDERS Last physical exam_____

Name	Phone	Care Provided and date of last visit

LABWORK, TESTS AND IMAGING WITHIN THE LAST YEAR

Date	Procedure	Results	Doctor

HOSPITALIZATIONS AND SURGERIES

Date	Hospital	Diagnosis/Operation	Doctor

Body Systems Review (please check all that apply):

0 = never 1 = rarely 2 = occasionally 3 = frequently 4 = always

0	1	2	3	4	low appetite	0	1	2	3	4	ravenous appetite
0	1	2	3	4	loose stools	0	1	2	3	4	heartburn/acid reflux
0	1	2	3	4	mouth sores	0	1	2	3	4	fatigue after eating
0	1	2	3	4	abdominal gas/bloating after food	0	1	2	3	4	bruise easily
0	1	2	3	4	gums (bleeding/swollen)	0	1	2	3	4	thirst
0	1	2	3	4	organ prolapsed (diagnosed)	0	1	2	3	4	belching or vomiting
0	1	2	3	4	spontaneous sweat	0	1	2	3	4	fatigue
0	1	2	3	4	allergies	0	1	2	3	4	catch colds easily
0	1	2	3	4	asthma	0	1	2	3	4	shortness of breath
0	1	2	3	4	general weakness	0	1	2	3	4	cough
0	1	2	3	4	dry nose/mouth/skin/throat	0	1	2	3	4	nasal discharge
0	1	2	3	4	feel worse after exercise	0	1	2	3	4	sinus congestion
0	1	2	3	4	sore, cold or weak knees	0	1	2	3	4	feel cold
0	1	2	3	4	low back pain	0	1	2	3	4	edema
0	1	2	3	4	frequent urination	0	1	2	3	4	urinary incontinence
0	1	2	3	4	early morning diarrhea	0	1	2	3	4	ear problems
yes		no			impaired memory	yes		no			hair loss
yes		no			infertility	high	normal		low		libido
0	1	2	3	4	muscle spasms/twitches	0	1	2	3	4	irritable
0	1	2	3	4	feel better after exercise	0	1	2	3	4	numb extremities
0	1	2	3	4	tight feeling in chest	0	1	2	3	4	dry eyes
0	1	2	3	4	alternating diarrhea/constipation	0	1	2	3	4	ear ringing
0	1	2	3	4	symptoms worse with stress	0	1	2	3	4	anger easily
0	1	2	3	4	neck/shoulder tension	0	1	2	3	4	red eyes
0	1	2	3	4	feel heart beating	0	1	2	3	4	chest pain
0	1	2	3	4	insomnia	0	1	2	3	4	disturbing dreams
0	1	2	3	4	sores on tip of tongue	0	1	2	3	4	headaches
0	1	2	3	4	anxiety	0	1	2	3	4	restlessness
0	1	2	3	4	chest pain traveling to shoulder						
high		normal			low overall body temperature						
high		normal			low overall energy level						
0	1	2	3	4	see floaters in eyes	0	1	2	3	4	foggy thinking
0	1	2	3	4	heat in palms or soles	0	1	2	3	4	dizzy upon standing
0	1	2	3	4	feeling of heaviness	0	1	2	3	4	nausea
0	1	2	3	4	afternoon fever	0	1	2	3	4	night sweats
0	1	2	3	4	enlarged lymph nodes	0	1	2	3	4	cloudy urine
0	1	2	3	4	face flushes						

Urination: Please circle any of the following symptoms you are currently experiencing:

Burning Urgent Retention Scanty

Profuse Dribbling Greater than 1x a night

Bowel Movements: Stools: Undigested food Blood Mucus

Frequency: When? _____ Feels complete? ☐ Yes ☐ No

Consistency: Well-formed Hard Loose Alternates

Stools: Undigested food Blood Mucus