



AcuHeal NOVA

Patient: _____

Female

Today's Date: _____

Medical History Form

Patient Name _____ DOB _____ Age _____

Patient Address _____

Patient City, State, ZIP _____

Patient Email Address _____

Patient Phone (H) _____ (W) _____

Occupation _____ Employer _____

Work Address _____

Work City, State, ZIP _____

Patient Relationship Status _____ Height _____ Weight _____

Partner's Name _____ DOB _____ Phone _____

Family Physician _____ Phone _____

How did you find us? Word of mouth Internet Advertisement

Emergency Contact Info

The name of the person you would like to contact in emergency _____

Phone (H) (____)____-____ Phone (W) (____)____-____ Relationship _____

Have you eaten 2 hours prior to your treatment? Yes No *You must eat within 2 hours prior to your treatment.*

Reason for Today's Visit

What is the reason for today's visit? _____

How long have you had this condition? _____

What seemed to be the initial cause? _____

What makes it better or worse? _____

Have you consulted your doctor? _____



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Health History

Check whether you or someone in your family have/ had the condition. Note the year for conditions you have had.

	You (yr)	Family		You (yr)	Family
Cancer	<input type="checkbox"/> _____	<input type="checkbox"/>	Herpes	<input type="checkbox"/> _____	<input type="checkbox"/>
- Type(s) _____			AIDS/HIV	<input type="checkbox"/> _____	<input type="checkbox"/>
Diabetes	<input type="checkbox"/> _____	<input type="checkbox"/>	Other STD	<input type="checkbox"/> _____	<input type="checkbox"/>
Hepatitis (A, B, C)	<input type="checkbox"/> _____	<input type="checkbox"/>	- Type(s) _____		
High Blood Pressure	<input type="checkbox"/> _____	<input type="checkbox"/>	Rheumatic Fever	<input type="checkbox"/> _____	<input type="checkbox"/>
Heart Disease	<input type="checkbox"/> _____	<input type="checkbox"/>	Alcoholism	<input type="checkbox"/> _____	<input type="checkbox"/>
Stroke	<input type="checkbox"/> _____	<input type="checkbox"/>	Allergies	<input type="checkbox"/> _____	<input type="checkbox"/>
Seizure Disorder	<input type="checkbox"/> _____	<input type="checkbox"/>	- Type(s) _____		
Thyroid Disease	<input type="checkbox"/> _____	<input type="checkbox"/>	Mental Illness	<input type="checkbox"/> _____	<input type="checkbox"/>
Asthma	<input type="checkbox"/> _____	<input type="checkbox"/>	- Type(s) _____		
Pacemaker	<input type="checkbox"/> _____	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/> _____	<input type="checkbox"/>
Osteoporosis	<input type="checkbox"/> _____	<input type="checkbox"/>	Anemia	<input type="checkbox"/> _____	<input type="checkbox"/>
Multiple Sclerosis	<input type="checkbox"/> _____	<input type="checkbox"/>	Thyroid Disorder	<input type="checkbox"/> _____	<input type="checkbox"/>

Notes: _____

Prescriptions & OTC Drugs

	Dose	Condition
1.	_____	_____
2.	_____	_____
3.	_____	_____
4.	_____	_____
5.	_____	_____
6.	_____	_____
7.	_____	_____
8.	_____	_____
Side effects:	_____	

Nutraceuticals & Vitamins

	Dose	Condition
1.	_____	_____
2.	_____	_____
3.	_____	_____
4.	_____	_____
5.	_____	_____
6.	_____	_____
7.	_____	_____
8.	_____	_____
Side effects:	_____	

Exercise

Do you exercise regularly?

Yes No

If so, what and how often?

Habits

Amt/Week If quit, year

Coffee/tea _____

Soda _____

Tobacco _____

Alcohol _____

Drugs _____

Surgeries

List what they were for & the date:



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Part A

- Shortness of breath
- Weak voice
- Little or no desire to speak
- Fatigue
- Spontaneous sweating
- Prefer quiet environments with less talking
- Dislike physical activity
- Weakness or lack of strength
- Frequent, small amounts of pale urine

Part B

- Cold, wearing warmer clothes than others
- Cold arms and legs or hands and feet
- Preference for hot drinks
- Wake up at night to urinate
- Frequent, copious amounts of clear/pale urine
- Dislike winter or air conditioned rooms
- Discomfort after eating cold foods
- Symptoms are worse during cold weather
- Tip of the nose is cold
- Absence of thirst

Part C

- Feeling of heat in the afternoon
- Hands and feet get hot
- Heat in the center of the chest, near the heart
- Dry, parched throat, especially at night
- Restless, uneasy, fidgety, agitated
- Cheeks and face get flushed
- Underweight
- Night sweats
- Hot flashes

Part D

- Head spins when standing up
- Numbness of hands and feet
- Dry or brittle skin, hair, or lips
- Brittle or withered nails
- Anxiety
- Loss of balance

Part E

- Bleeding of dark, clotted blood
- Bruises or bleeding under the skin
- Blood clots
- Black or very dark stools
- Spider veins or other visible veins

Part F

- Profuse bleeding of any kind
- Urinate small amounts of dark urine
- Hot-tempered
- Preference for cold drinks
- Very thirsty
- Bitter taste in the mouth all day
- Mouth sores
- Hot, warmer than the people nearby
- Halitosis, bad breath
- Head gets sweaty
- Always hungry
- Foul-smelling stools
- Bleeding gums

Part G

- Heaviness of head or body
- Pain and heaviness in joints
- Stickiness in the mouth
- Fatty bumps under the skin
- Edema or swelling
- Bone growths or deformities
- Feel heavy, slow, or sluggish



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- Runny nose or coughing up phlegm
- Bowel movements contain mucous
- Cloudy urine
- Thirst with no desire to drink

Part H

- Sores on the tongue
- Dream-disturbed sleep
- Difficulty falling asleep, but sleep well
- Angina
- Speech pathology (stutter, lisp, aphasia)
- Hyperactivity, excitability
- Can't think of the word you want to say
- Bitter taste in the mouth in the morning
- Palpitations; heartbeat feels too fast

Part I

- Symptoms that worsen with emotions
- Anger, frustration, bitterness
- Ribside pain
- Frequent sighing
- Feel like a lump is stuck in the throat
- Depression or mood swings
- Stressed out or irritable
- Clumsiness
- Blurred vision or floaters in your vision
- Constipation with bitty stools
- Alternating constipation and diarrhea
- Tinnitus, loud, high-pitched, like a whistle
- Dry eyes

Part J

- Cough
- Sneeze
- Struggling to breathe
- Unexpected sadness
- Asthma
- Catch colds easily
- Swelling of the eyes and face

Part K

- Abdominal bloating
- Lack of appetite
- Worry or excessive thinking
- Prolapsed organ (uterus, bladder, etc.)
- Sweet taste in your mouth
- Watery stools
- Feel sleepy after eating
- Loose stools containing undigested food
- Hemorrhoids
- Poor digestion
- Nausea

Part L

- Diarrhea first thing in the morning
- Brittle or loose teeth
- Weak bones
- Incontinence of urine or stools
- Sore or weak back or knees
- Difficulty inhaling a deep breath
- Premature graying or thinning hair
- Hearing impairment
- Salty taste in the mouth
- Wake up many times during the night
- Tinnitus, low-pitched, like rushing water
- Thirsty, prefer small sips of liquids
- Pressure in the eyes

Part M

- Dizziness
- Constipation
- Bowel movements contain blood
- Painful urination
- Wake early and can't fall asleep again
- Difficult urination
- Seizures



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Additional Health History

Please make an X on the scales and check any boxes of symptoms you have had in the past month. If you would like to add additional information, please do so on the following page.

Temperature

Cold
┌
└
 Hot

How warm/cold do you feel (not in degrees); relative to other people do you wear more or fewer layers of clothes, etc.

- | | | | |
|--|--|---|---|
| <input type="checkbox"/> Cold hands or feet | <input type="checkbox"/> Thirst for hot/cold drinks (circle) | <input type="checkbox"/> Night sweats | <input type="checkbox"/> Hot hands, feet, chest |
| <input type="checkbox"/> Chills | <input type="checkbox"/> Absence of thirst | <input type="checkbox"/> Unusual sweats | <input type="checkbox"/> Hot flashes |
| <input type="checkbox"/> Cold "in the bones" | <input type="checkbox"/> Thirst, but no desire to drink | - when ____am/pm | <input type="checkbox"/> Hot in the afternoon |
| <input type="checkbox"/> Areas of numbness | <input type="checkbox"/> Excessive thirst | - where on body _____ | <input type="checkbox"/> Hot at night |

Moisture

Dry
┌
└
 Oily

Your overall body moisture (hair, skin, mouth, bowels, etc.)

- | | | | |
|---|--|---|---|
| <input type="checkbox"/> Dry skin | <input type="checkbox"/> Dry mouth | <input type="checkbox"/> Edema/Swelling | <input type="checkbox"/> Oily skin |
| <input type="checkbox"/> Dry hair | <input type="checkbox"/> Dry lips | <input type="checkbox"/> Rashes | <input type="checkbox"/> Oily hair |
| <input type="checkbox"/> Dry eyes | <input type="checkbox"/> Dry throat | <input type="checkbox"/> Itching | <input type="checkbox"/> Pimples |
| <input type="checkbox"/> Dry, brittle nails | <input type="checkbox"/> Dry nose/nosebleeds | <input type="checkbox"/> Dandruff | <input type="checkbox"/> Weight gain/loss |

Digestion

Diarrhea
┌
└
 Constipation

- | | | | |
|---|--|---|---|
| BM: Freq? ____x/every ____ days | <input type="checkbox"/> Gas | <input type="checkbox"/> Nausea/Vomiting | <input type="checkbox"/> Dry stools |
| Stools keep shape? yes no | <input type="checkbox"/> Bloating | <input type="checkbox"/> Bad breath | <input type="checkbox"/> Stools difficult to pass |
| <input type="checkbox"/> Alt. diarrhea & const. | <input type="checkbox"/> Belching | <input type="checkbox"/> Heartburn | <input type="checkbox"/> Tired after BM |
| <input type="checkbox"/> Indigestion | <input type="checkbox"/> Poor appetite | <input type="checkbox"/> Excessive hunger | <input type="checkbox"/> Foul-smelling stools |

Energy

Low
┌
└
 High

- | | | | |
|---|--|---|--|
| <input type="checkbox"/> Sudden energy drop | <input type="checkbox"/> Dependence on caff/stimulants | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Hard to concentrate |
| - Time of day: ____am/pm | <input type="checkbox"/> Wired/ungrounded feeling | <input type="checkbox"/> Heart palpitations | <input type="checkbox"/> Poor memory |
| <input type="checkbox"/> Energy drop after eating | <input type="checkbox"/> Body/limbs feel heavy | <input type="checkbox"/> Blood pressure: high low | <input type="checkbox"/> Dizziness/Lightheaded |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Body/limbs feel weak | <input type="checkbox"/> Bleed/Bruise easily | <input type="checkbox"/> Headaches: ____x/week |

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Menses

Are you pregnant? yes no

Age at first menses: _____

Length of full cycle: _____ days

Length of menses: _____ days

Last menses start date: _____

of pregnancies _____

of births _____ preme _____

of abortions _____

of miscarriages _____

Heavy periods

Light periods

Painful periods

Irregular periods

Mid-cycle spotting

Mood changes

Fatigue w/menses

Changes in body/psyche
prior to menstruation (PMS)

Cramps

Before bleeding

First day

During period

Clots

Breast tenderness

Digestive changes w/mns

Endometriosis

Cysts/Fibroids

Vaginal discharge

Genital sores

Yeast infections

Birth control? yes no

type _____

Menopause

Age at last menses _____

Year menopause began _____

Vaginal dryness

Hot flashes _____x/day

Night sweats _____x/week

Loss of sex drive

Urinary

Fluid in = fluid out? yes no

Urgency to urinate

Painful urination

Incontinence

Kidney stones

Frequent urination

Burning urination

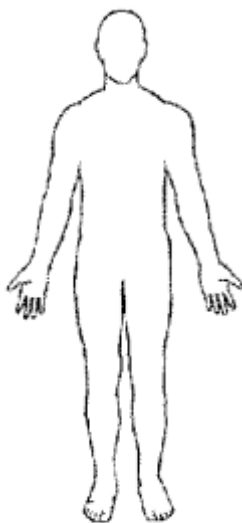
Cloudy urine

Blood in urine

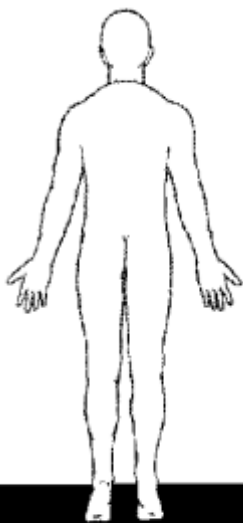
Pain & Injuries

Mark the location of any pain &/or injuries on the picture at left. Pain is (check all that apply): Additional information incl. onset date & cause

- Dull _____
- Achy _____
- Sharp _____
- Stabbing _____
- Burning _____
- Fixed _____
- Moves around _____
- Radiating _____
- Other _____



Front



Back

Additional Information
