Resonation Acupuncture

Katie Briggs, L.Ac.

Patient Medical History

Present Condition:

What is your chief complaint?

When did this begin?

Has a diagnosis already been made by another health care practioner? If so, what was the diagnosis, and who made it?

What treatments have you already received?

Are you currently under the supervision of a medical doctor or any other alternative therapy? (Please include names, address, and phone #s)

_____

_____

_____

Date of most recent exam _____

Health Habits

Check yes or no and indicate how much and how often you use each of the following items. Circle Day or week and indicate type.

Tobacco smoking	Y	N	_____packs per day	Type_____
Coffee	Y	N	_____cups per day/week	Type_____
Tea	Y	N	_____cups per day/week	Type _____
Alcohol	Y	N	_____drinks per day/week	Type_____
Recreational Drugs	Y	N	_____times per day/week	Type_____
Soft Drinks	Y	N	_____drinks per day/week	Type_____
Artificial Sweetener	Y	N	_____packs per day/week	Type_____

Medications, Herbs, Nutrients, and/or Vitamins (including dose and frequency):

_____

How many hour of sleep do you get a night?_____ Do you wake feeling rested?_____

Do you have adequate energy throughout the day? Y N

At what time is it highest?_____ lowest? _____

What kind of exercise do you get and how often?_____

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Please Circle your favorite flavor: Sour Bitter Sweet Spicy Salty

Are you on any specific type of diet at present?_____

Do you meditate /pray /use relaxation techniques? Y N

What do you feel passionate about?

Review of Systems:

Do you have now, or have you had any of the following with in the last year?

weight loss/ weight gain
fever
lumps under skin
visual problems
burning eyes, ears or throat
itching of eyes, ears, or throat
food cravings, intolerance to foods
thyroid problems
difficulty breathing
wheezing, shortness of breath
chest pain
arm pain
jaw pain
fast heartbeat
irregular heartbeats
shoulder pain
blood in vomit
blood in stool
black stools
abnormal Vaginal bleeding
painful urination
excessive urination
blood in urine
inadequate erections
low sex drive
difficulty enjoying sex
premature climaxing
difficulty remembering
frequent crying
nervousness
insomnia
depression
chemical sensitivity
exposure to toxins
dental fillings/ root canals
constipation, diarrhea, pain on defecation

Family History:

Father: alive deceased cause:_____ age:_____

Mother : alive deceased cause:_____ age:_____

Brother(s): alive deceased cause:_____ age:_____
alive deceased cause:_____ age:_____

Sisters(s): alive deceased cause:_____ age:_____
alive deceased cause:_____ age:_____

Illnesses related to blood relative: _____

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Medical History:

What surgeries have you had? When did you have them?

What other serious illnesses have you had?

Please indicate if you have had any of the following, and if so, when and why:

Hospitalizations [ ] Date(s)_____Cause(s)_____
Accidents [ ] Date(s)_____Cause(s)_____
Broken Bones [ ] Date(s)_____Cause(s)_____
Blood Transfusions [ ] Date(s)_____Cause(s)_____
Head Trauma [ ] Date(s)_____Cause(s)_____

Do you have any significant travel history, where you contracted an illness or disease that lasted more than 2 weeks?

Have ever been exposed to any such toxins such as chemicals, paints, radiation, chemotherapy, fumes, dust, solvents, etc.?

If you have ever had the following, please circle accordingly:

Cold Sores
Asthma
Pneumonia
Respiratory Infection
Diabetes Mellitus
Diabetes Insipidus
Emphysema
Scleroderma
Epstein Barr Virus (EBV)
Cytomegalovirus (CMV)
Lupus Erythmatosis (SLE)
Fibromyalgia
Rheumatoid Arthritis
Osteoarthritis
Genital Herpes
Hepatitis A
Hepatitis B
Hepatitis C
Epilepsy or Seizure Disorder
Heart Disease
High Blood Pressure
Kidney Disease
Cancer
Rheumatic Fever
Stroke
Tuberculosis
Bladder Problem/Infection
Bleeding Disorder
Jaundice
Hernia
Thyroid Disorder
Warts
Disorder of the Genitalia
Gynecological Disorders
Congenital Abnormalities
Skin Rashes or Diseases
Cardiac Pacemaker and/or Defibrillator
Surgical Implants
Hemorrhoids
Change in Bowel or Bladder Habits
Blood in Stool
Unusual Bleeding or Discharge
Peripheral Neuropathy
Tinnitus
Indigestion
Colitis
Chrone's Disease
Irritable Bowel Syndrome
Gallstones
Difficulty swallowing
Obvious change in a Wart or Mole
Cough
Hoarsness
Anemia or Other Blood Disorder
Peptic Ulcer
Gastric Ulcer
Pancreatitis
History of Smoking
History of Drinking Alcohol
History of Recreational Drugs
History of STD's
HIV or Aids