JEAN-CHRISTOPHE PRIN

ACUPUNCTURE • CLASSICAL CHINESE MEDICINE

# PATIENT HEALTH HISTORY

Full Legal Name:______________________________ Date:____________

Street Address: ______________________________

City:______________________ State:__________ Zip: ____________

Home Phone:______________ Cell:______________ Work: ______________

Date of Birth:____________ Age: ______ Gender: Female ❑ Male ❑ Transgender ❑ Other __________

Marital Status: ________ Occupation:____________________ Hours Per Week: ________

Employer:____________________ Email Address: ____________________

Emergency Contact:____________________ Phone:____________ Relationship: ________

Referred by (so I can thank them!) or how you heard about me: ____________________

## CHIEF COMPLAINT:

Reason for visit: ____________________

____________________

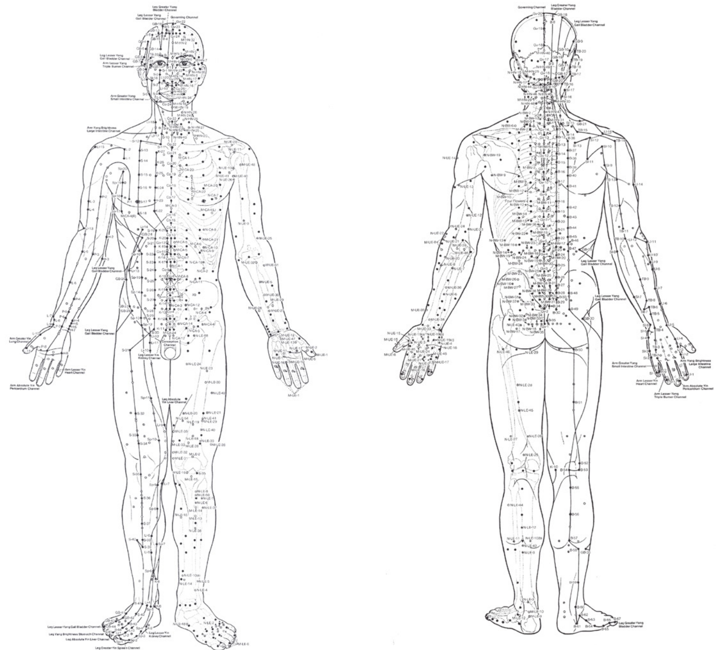
When did this condition begin? ____________

Describe symptoms you have now (mark region of pain on picture if applicable): ____________________

____________________

____________________

____________________



Please state diagnosis (if known): ____________

____________________

What diagnostic tests (if any) have been done for this?

____________________

____________________

____________________

What treatment(s) have you already received for this condition? ____________________

____________________

Has any treatment helped? (if yes, please explain) ____________________

____________________

Do you have any other health concerns? (Please list in order of importance):

1) ____________________

2) ____________________

3) ____________________

4) ____________________

5) ____________________

***Are you pregnant or have any reason to believe you may be pregnant?** ❑ Yes ❑ No

## ALLERGIES:

Are you allergic or hypersensitive to any foods, drugs, or environmental allergens? ❑ Yes ❑ No

If yes, please describe: ____________________

## CHRONIC ILLNESS:

Do you have any infectious/contagious disease? ❑ Yes ❑ No

If yes, please explain: ____________________

Are you currently suffering from any chronic illness? ❑ Yes ❑ No

If yes, please explain: ____________________

## MAJOR MEDICAL:

Please list all hospitalizations, surgeries, significant illnesses, or traumas you have experienced in your life:

1) ____________________ Date: __________

2) ____________________ Date: __________

3) ____________________ Date: __________

4) ____________________ Date: __________

5) ____________________ Date: __________

## CURRENT MEDICATIONS:

Please list all prescription medications (including hormones or birth control pills), over-the-counter medications, vitamins, herbs, or supplements you are currently taking and reason for taking them:

1) __________dosage: __________ reason: __________

2) __________dosage: __________ reason: __________

3) __________dosage: __________ reason: __________

4) __________dosage: __________ reason: __________

5) __________dosage: __________ reason: __________

6) __________dosage: __________ reason: __________

## NUTRITION:

Are you vegetarian or vegan? ❑ Yes ❑ No

Are you on any specific diets? ❑ Yes ❑ No If yes, please describe: __________

## OTHER:

Do you smoke cigarettes? ❑ Yes ❑ No If yes, how many per day?__________

Do you drink alcohol? ❑ Yes ❑ No If yes, how many drinks per week? __________

Is there anything else you would like me to know about you?__________

Overall, the state of your health is: ❑ Excellent ❑ Good ❑ Average ❑ Fair ❑ Poor

How much change are you willing to make for improving your health? ❑ Minimal ❑ Some ❑ Complete