



Healing InSight

ACUPUNCTURE
HERBS
FOOD THERAPY

Healing InSight

Health Assessment

Thank you for choosing Healing InSight!

We are delighted to work with you to restore your body's natural rhythm.

The answers you will provide on these forms and the discussions you will share with your practitioner all add up - like individual pieces of a puzzle - to reveal a larger picture of your health and health concerns. This holistic view allows your concerns to be addressed from both a specific *branch* level and also a deeper *root* level.

Please take time to thoughtfully and honestly answer these questionnaires so that the picture of your health and health concerns are revealed as clearly as possible.

Name: _____ Today's Date: _____

Address _____

City: _____ State: _____ Zip: _____

Primary Phone # _____ Secondary Phone # _____

E-mail Address _____

Would you like to join Healing InSight's email list and be the first to know about upcoming health seminars and exclusive specials? Yes No I'm already on it!

Date of Birth _____ Age _____ Weight _____ Height _____ Sex M / F

Marital Status: Single Married or living with significant other
 Separated Divorced Widowed

Employer _____ Occupation _____

Emergency Contact _____ Phone _____

How did you hear about us? _____

Have you ever received acupuncture before? _____

*Full payment is due on the day of the appointment.
Receipts for insurance reimbursement will be provided at your request.*

*We ask for 24 hour advance notice if you need to cancel an appointment.
You may be charged if you cancel an appointment without 24 hours notice.*

Patient ID _____

Healing InSight
Medical History

What health concern(s) bring you in today? _____

How do these affect your daily life? _____

Have you been examined by a medical doctor for any of these health concerns? Yes / No

If yes, what was the diagnosis? _____

Do you have other health concerns you wish we could help? _____

List any major surgeries you've had _____

Significant trauma (accidents, falls) _____

Have you ever been diagnosed with any of the following:

- | | | | |
|---------------------------------------|--|---------------------------------------|---------------------------------------|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Anemia | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Low blood pressure | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Blood clots | <input type="checkbox"/> Substance addiction | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Peripheral neuropathy | <input type="checkbox"/> Depression | <input type="checkbox"/> HIV/AIDS |
| <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Ulcer/GI bleeding | <input type="checkbox"/> Anxiety | <input type="checkbox"/> Hepatitis |

Dental issues: Root canal Tooth abscess Metal fillings Crown/implant

Family medical history (parents, siblings, grandparents) _____

Past medications (current medications will be listed on a separate form)

- | | | |
|--|--|---|
| <input type="checkbox"/> Contraceptives | <input type="checkbox"/> Pain medication | <input type="checkbox"/> Anti-hypertensives |
| <input type="checkbox"/> Antidepressants | <input type="checkbox"/> Long-term antibiotics | <input type="checkbox"/> Cholesterol-lowering drugs |
| <input type="checkbox"/> Steroids | <input type="checkbox"/> Antacids | <input type="checkbox"/> Other _____ |

Patient ID _____

Healing InSight
Health History

Please mark any symptoms you currently have or have had in the past year.

TEMPERATURE

- Tend to feel hot
- Tend to feel cold
- Hot flashes
- Chills
- Fever
- Alternating chills and fever

PERSPIRATION/THIRST

- Sweat with little exertion
- Night sweats
- Can't sweat
- Thirsty and drink cold
- Thirsty and drink hot
- Thirsty but don't drink
- Not thirsty

ENERGY

- High energy/nervous
- Good energy
- Okay energy/slightly low
- Low energy/fatigue

HEAD

- Headaches
- Migraines
- Dizzy/lightheaded
- Fainting
- Foggy-headedness
- Seizures
- Tremors
- Sinus congestion
- Nasal discharge

SENSES

- Declining vision
- Eyes sensitive to light
- Red/itchy eyes
- Floating spots in vision
- Poor hearing
- Ear ringing
- Poor sense of smell
- Earaches
- Decreased night vision

MOUTH

- Frequent sore throats
- Poor teeth
- Mouth/canker sores
- Lip sores
- Dry/chapped lips
- Dry mouth and throat
- Lump in the throat
- Swollen/painful gums
- Taste in mouth, describe _____

SKIN, HAIR & NAILS

- Thin skin/nails
- Dry skin/nails
- Easily bruised
- Dark under eyes
- Lumps
- Acne
- Abscesses/infection
- Prematurely gray hair
- Hair loss
- Dry/brittle hair

LUNGS & HEART

- Wheezing
- Coughing
- Short of breath
- Tight sensation in chest
- Frequent colds, >2/year
- Seasonal allergies
- Slow heart rate
- Fast heart rate
- Irregular heart rhythm
- Palpitations/fluttering sensation
- Chest pain
- High blood pressure
- Low blood pressure

APPETITE & DIGESTION

- Excessive appetite
- Poor appetite
- Excessive saliva
- Heartburn/reflux
- Nausea/vomiting
- Gas
- Tired after eating
- Bad breath
- Bloating/distention
- Abdominal pain
- Stomach pain
- Belching/hiccups
- Gall stones
- Pain under ribs

CRAVINGS

- Sweet
- Salty
- Sour
- Bitter
- Hot/spicy
- Strong flavor/pungent
- Bland
- Crunchy
- Other _____

BOWEL MOVEMENTS

- Constipation
- Loose stool/diarrhea
- Alternating constipation and diarrhea
- Cramps with BM
- Incomplete BM
- Burning with BM
- Hemorrhoids
- Bowel incontinence
- Blood or mucus in stool
- Foul odor
- Green stool

URINATION

- Dark urine
- Cloudy urine
- Burning urination
- Scanty urine
- Profuse urine
- Decreased bladder control
- Frequent urination
- Wake at night twice or more to urinate
- Frequent UTIs
- Kidney stones

SLEEP

- Insomnia
- Excessive sleep
- Difficulty falling asleep
- Wake during the night
- Lots of vivid dreams
- Disturbing dreams
- Don't get enough sleep
- Wake unrefreshed

Number of hours of sleep each night _____

MENTAL & EMOTIONAL

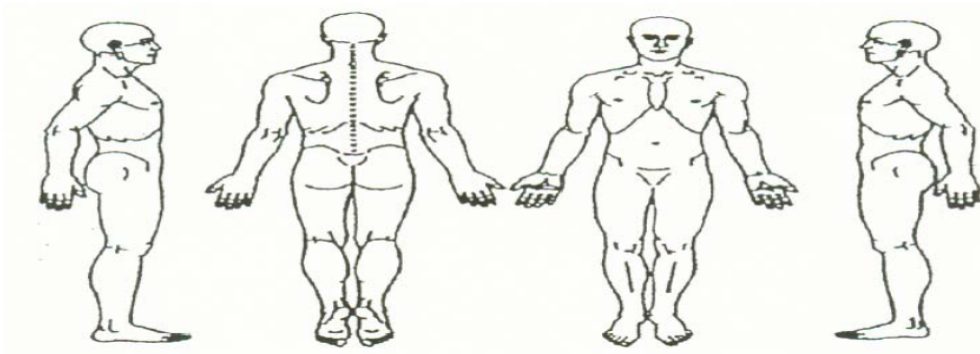
- Forgetful/poor memory
- Poor concentration
- Irritable/angry
- Sad
- Tearful/weepy
- Restless
- Anxious/worried
- Can't stop thinking
- Fearful/easily startled
- Manic
- Depressed
- Frequent sighing or yawning

DIET & LIFESTYLE

- Poor diet
- Consume caffeine daily
- Smoke cigarettes
- Chew tobacco
- Drink alcohol
- Use drugs
- Too little activity/exercise
- Exercise excessively
- Eating disorder
- Job stress/concerns
- Family stress/concerns
- Other stress/concerns

MUSCULOSKELETAL & EXTREMITIES

Mark any areas where you experience pain or numbness



- TMJ
- Scoliosis
- Joint swelling
- All over body pain
- Muscle tightness
- Cold back or knees
- Weak back or knees
- Body heaviness
- Swelling/edema

Women's Health History

GENERAL GYNECOLOGY

- High sexual energy
- Low sexual energy
- Chronic vaginal discharge
- Regular yeast infections
- Vaginal dryness
- Breast lumps/nodules
- Mastitis
- Cysts
- Endometriosis
- Pelvic abnormalities/adhesions
- Fibroids
- PID
- STDs
- Abnormal pap smear
- Uterine or bladder prolapse
- Others _____

REPRODUCTIVE HISTORY

Are you currently using birth control? Y / N

Are you trying to conceive? Y / N

Are you currently lactating? Y / N

How many pregnancies have you had? ____

How many children do you have? ____

How many abortions have you had? ____

How many miscarriages have you had? ____

Have you had any:

- High-risk pregnancies
- Difficult labor/deliveries
- Postpartum concerns
- Lactation concerns

MENOPAUSE

- Peri-menopausal
- Post-menopause since _____
(Please answer menstruation questions to the best of your recollection)

MENSTRUATION

Age when menses began _____

Menstruation lasts _____ days

Regular cycle: _____ days total

Irregular: _____ to _____ days

Can you tell when you ovulate? Y / N

During your period, the flow is:

Light/spotting on days _____

Medium on days _____

Heavy on days _____

With clots on days _____

Spotting between periods

What color is the blood?

Light Red on days _____

Bright Red on days _____

Dark Red on days _____

Purple on days _____

Brown on days _____

Black on days _____

PMS

- Acne
- Cramps/Backache
- Bowel changes
- Breast changes
- Food cravings
- Irritability/anger
- Nausea
- Sad/Weeping
- Others _____

POST-MENSTRUATION

- Dizziness
- Fatigue
- Insomnia
- Night sweats
- Others _____

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