MAGIC MOON HEALING ARTS
ACUPUNCTURE, SHIATSU & REIKI
LAC #2198

Patient Health History

Name: _____ Date: _____/_____/_____
(first) (middle) (last)

Date of Birth: _____/_____/_____ Age: _____ Marital status: S M D W Partnered

Address: _____City: _____ State:_____

Zip:_____ Phone #: _____ (Cell? Home?) Email: _____

Is it okay to leave messages about appointment scheduling? Y N With : Phone or Email

Successful health care and preventative medicine are only possible when the practitioner has a complete understanding of the patient physically, mentally and emotionally. Please complete this questionnaire as thoroughly as possible. Print all information and indicate areas of confusion with a question mark. Thank you. If you need more room, please use the backside of the page.

1. When and where did you last receive health care? _____

For what reason? _____

2. Have you ever had Acupuncture / Shiatsu / Reiki / cupping / gua sha / or moxa ? Please circle the modalities you have received before.

What are your concerns about receiving Acupuncture, Shiatsu or Reiki? _____

_____

3. **What are your most pressing health concerns in order of importance to you? What is the chief concern you would like to address today?**

Condition **Past Treatment**

a. _____ _____

How does this condition affect you? _____

b. _____ _____

How does this condition affect you? _____

c. _____ _____

How does this condition affect you? _____

4. If applicable, please list any foods, drugs, medications, chemicals or anything else you are hypersensitive or allergic to:

_____

_____

5. Please list any medications (prescribed and over-the-counter), vitamins & herbs you are currently taking:_____

_____

_____

6. Do you have any reason to believe you may be pregnant? Y N

7. Do you have any infectious diseases? Y N If yes, please identify: _____

8. **Family History:** Check those applicable:	Father	Mother	Brothers	Sisters	Spouse	Children
Age (if living)	_____	_____	_____	_____	_____	_____
Health (G=Good, P=Poor)	_____	_____	_____	_____	_____	_____
Cancer	_____	_____	_____	_____	_____	_____
Diabetes	_____	_____	_____	_____	_____	_____
Heart Disease	_____	_____	_____	_____	_____	_____
High Blood Pressure	_____	_____	_____	_____	_____	_____
Stroke	_____	_____	_____	_____	_____	_____
Mental Illness	_____	_____	_____	_____	_____	_____
Asthma/Hay fever/Hives	_____	_____	_____	_____	_____	_____
Kidney Disease	_____	_____	_____	_____	_____	_____
Age (at death)	_____	_____	_____	_____	_____	_____
Cause of Death	_____	_____	_____	_____	_____	_____

9. **Height:** _____ **Weight:** Currently: _____ Past Maximum: _____ When? _____

10. **Childhood Illness** (please circle any that you have had):

Rheumatic Fever Mumps Measles German Measles Chicken Pox Chronic ENT infections

11. **Hospitalizations / Surgeries / Broken bones.**

Type / Reason	When
_____	_____
_____	_____
_____	_____

12. **X-Rays/CAT Scans/MRI's/NMR's/Special Studies:**

Type/Reason	When
_____	_____
_____	_____
_____	_____

Please circle any symptoms that you experience now and underline any you have experienced in the past:

13. **Mental / Emotional:**

Mood Swings	Nervousness	Mental Tension	Anxiety	Insomnia
Depression	Past Trauma	Recent Trauma		

14. **Energy and Immunity:**

Fatigue	Slow Wound Healing	Chronic Infections	Immune Disorder

15. **Head, Eye, Ear, Nose, and Throat:**

Impaired Vision	Eye Pain/Strain	Glaucoma	Glasses/Contacts	Tearing/Dryness
Impaired Hearing	Ear Ringing	Earaches	Headaches	Sinus Problems
Nose Bleeds	Frequent Sore Throats	Teeth Grinding	TMJ/Jaw Problems	Allergies

16. **Respiratory**:

Pneumonia	Frequent Common Colds	Difficulty Breathing	Emphysema
Persistent Cough	Asthma	Tuberculosis	Shortness of Breath

17. **Cardiovascular**:

Heart Disease	Chest Pain	Swelling of Ankles	High Blood Pressure	
Palpitations/Fluttering	Stroke	Heart Murmurs	Rheumatic Fever	Varicose Veins

18. **Gastrointestinal**:

Ulcers	Changes in Appetite	Nausea/Vomiting	Epigastric Pain	Gas/ Burping	Heartburn/Reflux
Gall Bladder Disease	Liver Disease	Hepatitis B or C	Hemorrhoids	Abdominal Pain	

19. **Genito-Urinary Tract**:

Kidney Disease	Painful Urination	Frequent UTI	Frequent Urination	Heavy Flow
Kidney Stones	Impaired Urination	Blood in Urine	Frequent Urination at Night	

20. **Female Reproductive/Breasts** :

Irregular Cycles	Breast Lumps/Tenderness	Nipple Discharge	Heavy Flow
Vaginal Discharge	Premenstrual Problems	Clotting	Bleeding Between Cycles
Menopausal Symptoms	Difficulty Conceiving	Painful Periods	

21. **Menstrual/Birthing History:**

1. Age of First Menses: _____	4. Birth Control Type: _____	7. # of Abortions: _____
2. # of Days of Menses: _____	5. # of Pregnancies: _____	8. # of Live Births: _____
3. Length of Cycle: _____	6. # of Miscarriages: _____	

22. **Male Reproductive**:

Sexual Difficulties Prostrate Enlargement Testicular Pain/Swelling Penile Discharge

23. **Musculoskeletal (Left / Right / Both)**

Neck/Shoulder Pain Muscle Spasms/Cramps Arm Pain Upper Back Pain Mid Back Pain

Low Back /Hip Pain Leg Pain Joint Pain (if so, where?)_____

24. **Neurologic**:

Vertigo/Dizziness Numbness/Tingling Loss of Balance Seizures/Epilepsy

25. **Endocrine**:

Hypothyroid Hypoglycemia Hyperthyroid Diabetes Night Sweats Feeling Hot or Cold

26. **Other**:

Anemia Rashes Eczema/Hives Cold Hands/Feet Dental issues Cancer (location?)

27. **Is there anything else I should know?** _____

_____

28. **Lifestyle:**

a. Do you typically eat at least three meals per day? Y N If no, how many? _____

b. Exercise routine: _____

c. Spiritual practice: _____

d. Do you feel supported by your friends and family? Y N

e. How many hours per night do you sleep? _____ Do you wake rested? Y N

f. Occupation: _____

g. Hours/Week: _____

Do you enjoy work? Y/N Why/Why not? _____

g. Nicotine/Alcohol/Caffeine Use: _____

h. Have you experienced any major traumas? Y N Explain: _____

_____

i. How many glasses of non-caffeinated, non-carbonated beverages do you drink per day? _____

j. Television habits: _____ Reading habits: _____

k. Interests and hobbies: _____

Patient Signature X_____ Date _____