NORTHWESTERN
HEALTH SCIENCES
UNIVERSITY

Oriental Medicine Health History Form

For Office Use Only:

__ Bloomington Natural Care Center
__ Highland Natural Care Center
__ Woodwinds Natural Care Center
__ Edith Davis Teaching Clinic

Clinic Theater: ☐ Yes ☐ No

Date: ______________________

Account Number: ______________________

Name:____
Last First Middle Initial

Address:____

City:______________________ State:________ Zip:__________ Home Phone: ______________________

Work Phone____________________ E-mail Address:________________________________

Employer: ______________________________ Occupation: ______________________________

Emergency Contact (Other than someone you live with) : ________________________________

Emergency Contact Phone Number: ________________________________

1. Age: __________(yrs) Date of birth: _____/______/_______
month day year

2. Female……☐1 Male……☐2

3. What is your height? ______ Feet ______ Inches

4. What is your weight? __________ lbs.

5. Who referred you for this appointment?

☐1 ……NWHSU Student
☐2 ……NWHSU Employee
☐3 ……MCAOM Clinic Client
☐4 ……Advertising (e.g. mailing, phone book)
☐5 ……MD / Medical Clinic
☐6 ……Chiropractor
☐7 ……Other:________________________________
☐8 ……No Referral

6. How much schooling have you completed? (Please check one)

- ☐1 ……Completed less than high school
- ☐2 ……Graduated from High School
- ☐3 ……Completed 1-3 years of college
- ☐4 ……Graduated from a 2-year Associate degree program or technical school
- ☐5 ……Graduated from college
- ☐6 ……Completed post-graduate or professional program

7. Which of the following describe your current employment situation?

(Check all that apply)

- ☐1 ……Currently working (number of hours a week): ________________________________
- ☐2 ……On paid leave
- ☐3 ……On Unpaid leave
- ☐4 ……Unemployed
- ☐5 ……Homemaker
- ☐6 ……Student
- ☐7 ……Retired
- ☐8 ……Disabled and/or retired because of my health problem (specify type)__________________________

8. Ethnicity

- ☐1 ……Hispanic/Latino
  (country of origin): ______________________
- ☐2 ……Non-Hispanic
  (country of origin): ___________________________

9. Race (Check all that apply)

- ☐1 ……Asian or Pacific Islander
- ☐2 ……Black/African American
- ☐3 ……Hispanic
- ☐4 ……American Indian or Alaskan Native
- ☐5 ……White
- ☐6 ……Other ______________________

10. Marital Status (Please check most current status)

- ☐1 ……Married or living with significant other
- ☐2 ……Divorced/Separated
- ☐3 ……Widowed
- ☐4 ……Never been married

11. Have you been treated with Traditional Chinese Medicine in the past?

☐0 ……No

☐1 ……Yes (please explain)________________________________

12. What type of health issue brings you here today?

(Check all that apply and provide a brief description)

☐1 ……Pain: ________________________________

☐2 ……Long-term illness:________________________________

☐3 ……Sudden illness:________________________________

☐4 ……Stress Management: ________________________________

☐5 ……General Wellness: ________________________________

☐6 ……Other:________________________________

13. When did your health issue begin?

☐1 ……Less than 6 weeks ago

☐2 ……6 weeks – 3 months ago

☐3 ……3 months – 1 year ago

☐4 ……More than 1 year ago

☐88 ……NOT APPLICABLE: Here for General Wellness

14. a) Have you seen another health care provider for this health issue?

☐0 ……No

☐1 ……Yes…..What was the diagnosis? ________________________________

☐88 ……NOT APPLICABLE: Here for General Wellness

b) Are you still being seen by another health care provider for this health issue?

☐0 ……No

☐1 ……Yes

☐88 ……NOT APPLICABLE: Here for General Wellness

15. What is the severity of your health issue TODAY?
(Circle only one number)

0	1	2	3	4	5	6	7	8	9	10

No problem at all **As bad as it can be**

16. On average, what was the typical severity of your health issue in the LAST WEEK?
(Circle only one number)

0	1	2	3	4	5	6	7	8	9	10

No problem at all **As bad as it can be**

17. Diet

A. How is your appetite? (Please check one)

☐0 ……Absent
☐1 ……Weak
☐2 ……Moderate
☐3 ……Strong

B. What tastes or foods do you crave? (Please check all that apply)

☐1 …...Sweet
☐2……Salty
☐3……Sour
☐4 ……Hot/spicy
☐5…….Bland
☐6 ……Other: ______________________
☐7…….None

18. Exercise

On average, how often have you engaged in exercise or sports activities in the past month?

(Check only one box)

☐$_0$ ……I do not engage in exercise or sports

☐$_1$ ……Less than once a week

☐$_2$ ……Once a week

☐$_3$ ……2 or 3 times a week

☐$_4$ ……4 times or more a week

19. Sleep

A. On average, how many hours do you sleep each night? ___________

B. On average, how would you rate your sleep?

☐$_0$……Poor

☐$_1$……Average

☐$_2$……Excellent

C. Do you ever experience any of the following? (Please check all that apply)

☐$_1$……Hard to fall asleep

☐$_2$……Restless sleep

☐$_3$……Wake up too early

☐$_4$……Feel hot or sweat at night

☐$_5$……Insomnia with indigestion

☐$_6$……Easy wakening, hard to fall back to sleep

☐$_7$……Wake tired in the morning

☐$_8$……Excessive or disturbing dreams

☐$_9$ ……Other: ____

☐$_{10}$……None of the above - I have no problems with my sleep.

20. Habits

A. Do you currently smoke? (Check only one box)

☐$_0$…… No

☐$_1$…… Yes

B. Do you drink alcohol? (Check only one box)

☐$_0$…… No

☐$_1$ ……Yes, approximately _____ drinks per week.

C. Do you drink caffeinated drinks? (Check only one box)

☐$_0$……No

☐$_1$……Yes, approximately ____ drinks per week.

21. Prior Health History

A. Childhood illnesses: ______________________________

B. Past Traumas: ______________________________

C. Family History**:**______________________________

D. Allergies:______________________________

22. Have you ever been diagnosed with any of the following?

(Please answer each item)

No$_0$	**Yes**$_1$			**No**$_0$	**Yes**$_1$	
☐	☐	1. Migraine Headaches		☐	☐	12. Arthritis (osteoarthritis)
☐	☐	2. High Blood Pressure		☐	☐	13. Rheumatoid Arthritis
☐	☐	3. Asthma		☐	☐	14. TMJ (jaw pain)
☐	☐	4. Heart Attack		☐	☐	15. Anemia
☐	☐	5. Congestive Heart Failure		☐	☐	16. Systemic Lupus
☐	☐	6. Stroke		☐	☐	17. HIV/AIDS
☐	☐	7. Diabetes		☐	☐	18. Hepatitis
☐	☐	8. Cancer/Tumor		☐	☐	19. Irritable Bowel Syndrome
☐	☐	9. Epilepsy		☐	☐	20. Ulcers
☐	☐	10. Depression/ Anxiety		☐	☐	21. Gastritis
☐	☐	11. Fibromyalgia				

23. Do you experience any of the following? (Please answer each item)

No$_0$	Yes$_1$		No$_0$	Yes$_1$	
☐	☐	1. Headaches	☐	☐	33. Dry cough
☐	☐	2. Neck pain	☐	☐	34. Productive cough
☐	☐	3. Back pain	☐	☐	35. Coughing blood
☐	☐	4. Shoulder pain	☐	☐	36. Difficulty breathing
☐	☐	5. Elbow / arm pain			
☐	☐	6. Wrist / hand pain	☐	☐	37. Nausea
☐	☐	7. Hip / upper leg pain	☐	☐	38. Vomiting
☐	☐	8. Knee / lower leg pain	☐	☐	39. Abdominal pain or cramps
☐	☐	9. Ankle / foot pain	☐	☐	40. Belching
			☐	☐	41. Gas
☐	☐	10. Loss of balance	☐	☐	42. Heartburn (acid-reflux)
☐	☐	11. Dizziness or fainting	☐	☐	43. Changes in appetite
☐	☐	12. Ringing in ears	☐	☐	44. Constipation
☐	☐	13. Hearing loss	☐	☐	45. Diarrhea
☐	☐	14. Frequent earaches	☐	☐	46. Changes in bowel habits
☐	☐	15. Sinus problems			
			☐	☐	47. Chest pain
☐	☐	16. Dry mouth / throat	☐	☐	48. Heart palpitations (fluttering)
☐	☐	17. Mouth sores	☐	☐	49. Irregular pulse
☐	☐	18. Bad breath	☐	☐	50. Varicose veins
☐	☐	19. Frequent sore throats			
			☐	☐	51. General fatigue / poor energy
☐	☐	20. Changes in urine color	☐	☐	52. Feeling depressed
☐	☐	21. Painful urination	☐	☐	53. Mood swings
☐	☐	22. Changes in urine flow			
☐	☐	23. Frequent urination	☐	☐	54. Changes in weight
☐	☐	24. Waking at night to urinate	☐	☐	55. Fever/ hot temperature
☐	☐	25. Poor bladder control	☐	☐	56. Chills/ cold temperature
☐	☐	26. Impotence / erectile dysfunction			
☐	☐	27. Prostate problems	☐	☐	57. Rashes
☐	☐	28. Bladder infections	☐	☐	58. Easy bruising
☐	☐	29. Itching in genital area	☐	☐	59. Acne
☐	☐	30. Vision loss	☐	☐	60. Abnormal sweating
☐	☐	31. Seeing spots / floaters	☐	☐	61. Cold hands / feet
☐	☐	32. Drug / alcohol dependence	☐	☐	62. Hair loss

24. If you are FEMALE, do you experience any of the following? (Please answer each item)

No$_0$	Yes$_1$	
☐	☐	1. Painful menses
☐	☐	2. Irregular menses
☐	☐	3. Premenstrual changes
☐	☐	4. Menstrual clots
☐	☐	5. Heavy menstrual flow
☐	☐	6. Light menstrual flow

No$_0$	Yes$_1$	
☐	☐	7. Strong menstrual odor
☐	☐	8. Vaginal discharge
☐	☐	9, Strong vaginal odor
☐	☐	10. Hot flashes
☐	☐	11. Onset of menopause
☐	☐	12. Infertility

25. If you are FEMALE, please answer the following:

a. Number of pregnancies………………… _______

b. Number of live births……………………. _______

c. Number of miscarriages / abortions…… _______

d. Typical menstrual color……………….. _______

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26. Please indicate which statements best describe your own health state today.

(Choose one answer for each section)

a) Mobility

☐1 ......I have no problems in walking about

☐2 ......I have some problems in walking about

☐3 ......I am confined to bed

b) Self-Care

☐1 ......I have no problems with self-care

☐2 ......I have some problems washing or dressing myself

☐3 ......I am unable to wash or dress myself

c) Usual Activities (e.g. Work, study, housework, family or leisure activities)

☐1 ......I have no problems with performing my usual activities

☐2 ......I have some problems with performing my usual activities

☐3 ......I am unable to perform my usual activities

d) Pain/Discomfort

☐1 ......I have no pain or discomfort

☐2 ......I have moderate pain or discomfort

☐3 ......I have extreme pain or discomfort

e) Anxiety/Depression

☐1 ......I am not anxious or depressed

☐2 ......I am moderately anxious or depressed

☐3 ......I am extremely anxious or depressed

f) Compared with my general level of health over the past 12 months, my health state today is…

☐1 ......Better

☐2 ......Much the same

☐3 ......Worse

27. To help people describe how good or bad a health state is, we have drawn a scale (rather like a thermometer) on which the **best state you can imagine** is marked by **100** and the **worst state you can imagine** is marked by **0**.

We would like you to indicate on this scale how good or bad your own health is **today**, in your opinion.

Please do this by drawing a line from the box below to whichever point on the scale indicates how good or bad your current health state is today.

Best imaginable health state

Your own health state today

Worst imaginable health state