SOLSTICE
A Holistic Approach To Health

Medical History
Confidential

General Information

Patient Name____________________
Patient Address____________________
City____________ State____________ Zip____________
Home Phone ____________ Work Phone____________
Gender ❑ Male ❑ Female Age________ DOB ___/___/___ Weight____________
Marital Status____________ Occupation____________

Primary Practitioner (Medical Doctor)____________ Date of last visit___/___/___
Reason for Visit____________________

Have you received acupuncture/Chinese Herbs in the past? ❑ Yes ❑ No
Name of Acupuncturist ____________ Date of last visit___/___/___
Reason for Visit____________________

Emergency Contact

Name____________ Relationship____________
Address____________ Phone____________

Major Concern

What is your primary reason for this visit?____________________

____

____

This condition is due to ❑ Automobile Injury ❑ Work Injury ❑ Sports Injury ❑ Illness ❑ Not sure ❑ Other
If Other, please explain____________________

What was the date of the illness or injury?___/___/___ When did your symptoms begin?___/___/___

Did your symptoms develop? ❑ Gradually or ❑ Suddenly How long do symptoms last?____________

Is there a pattern to when your symptoms occur? ❑ Yes ❑ No
if yes, what is the pattern? ❑ In the morning ❑ Occasionally ❑ During sleep
❑ In the evening ❑ Intermittently ❑ Upon waking
❑ All day ❑ Constantly ❑ Other____________

____

What initiates your symptoms?____________________
What makes them worse?____________________
What makes them better?____________________
Have you received treatment for this concern? ❑ yes ❑ no
If yes, what was done and did it help?____________________

Do you have specific questions you would like to discuss today?____________________

____

____

Family History

Father ❑ Living Age_______ ❑ Deceased Age at Death_______ Cause___________________________________

Mother ❑ Living Age_______ ❑ Deceased Age at Death_______ Cause___________________________________

Spouse ❑ Living Age_______ ❑ Deceased Age at Death_______ Cause___________________________________

Siblings Gender ❑ Male ❑ Female Health Status____

Gender ❑ Male ❑ Female Health Status____

Children Gender ❑ Male ❑ Female Health Status____

Gender ❑ Male ❑ Female Health Status____

Check illness(es) which have occurred in any of your blood relatives

❑ Alcoholism ❑ Bleed Easily ❑ Diabetes ❑ Heart Disease ❑ Kidney Disease ❑ Obesity ❑ Allergy ❑ Cancer

❑ Epilepsy ❑ High Blood Pressure ❑ Mental Illness ❑ Stroke ❑ Other__________________________________

Personal History

How would you describe your health as a child?____

____

Check any illnesses or conditions you have had in the past.

❑ Alcoholism	❑ Hepatitis	❑ Pacemaker
❑ Allergies	❑ High Blood Pressure	❑ Pneumonia
❑ Antibiotic Use	❑ High Fevers	❑ Polio
❑ Asthma	❑ HIV/AIDS	❑ Stroke
❑ Bleed Easily	❑ Jaundice	❑ Thyroid Disorders
❑ Cancer	❑ Kidney Disease	❑ Tuberculosis
❑ Chicken Pox	❑ Measles	❑ Typhoid Fever
❑ Diabetes	❑ Meningitis	❑ Ulcers
❑ Epilepsy	❑ Mental Disorder	❑ Vascular Disease
❑ Glaucoma	❑ Multiple Sclerosis	❑ Venereal Disease
❑ Heart Disease	❑ Mumps	❑ Other: ____________________

List illnesses not requiring surgery for which you have been hospitalized______________________________

____

List illnesses requiring surgery (include dates)____

____

List any other serious injury, broken bones, scars, etc.____

____

List allergies or sensitivities to medications or other substances_____________________________________

____

List date and results of last medical test (ie: physical, cholesterol, hepatitis, mammography, stool, HIV test, PSA (prostate), Pap smear, or other)

Date____/_____/_____ Test____________________ Result____

Date____/_____/_____ Test____________________ Result____

Date____/_____/_____ Test____________________ Result____

Date____/_____/_____ Test____________________ Result____

Anything else you would like to tell us?____

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