

Resonation Acupuncture

Katie Briggs, L.Ac.

Patient Medical History

Present Condition:

What is your chief complaint?

When did this begin?

Has a diagnosis already been made by another health care practitioner? If so, what was the diagnosis, and who made it?

What treatments have you already received?

Are you currently under the supervision of a medical doctor or any other alternative therapy? (Please include names, address, and phone #s)

Date of most recent exam _____

Health Habits

Check yes or no and indicate how much and how often you use each of the following items. Circle Day or week and indicate type.

Tobacco smoking	Y	N	_____ packs per day	Type _____
Coffee	Y	N	_____ cups per day/week	Type _____
Tea	Y	N	_____ cups per day/week	Type _____
Alcohol	Y	N	_____ drinks per day/week	Type _____
Recreational Drugs	Y	N	_____ times per day/week	Type _____
Soft Drinks	Y	N	_____ drinks per day/week	Type _____
Artificial Sweetener	Y	N	_____ packs per day/week	Type _____

Medications, Herbs, Nutrients, and/or Vitamins (including dose and frequency):

How many hours of sleep do you get a night? _____ Do you wake feeling rested? _____

Do you have adequate energy throughout the day? Y N

At what time is it highest? _____ lowest? _____

What kind of exercise do you get and how often? _____

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Please Circle your favorite flavor: Sour Bitter Sweet Spicy Salty

Are you on any specific type of diet at present? _____

Do you meditate /pray /use relaxation techniques? Y N

What do you feel passionate about?

Review of Systems:

Do you have now, or have you had any of the following with in the last year?

- | | |
|-------------------------------------|--|
| weight loss/ weight gain | black stools |
| fever | abnormal Vaginal bleeding |
| lumps under skin | painful urination |
| visual problems | excessive urination |
| burning eyes, ears or throat | blood in urine |
| itching of eyes, ears, or throat | inadequate erections |
| food cravings, intolerance to foods | low sex drive |
| thyroid problems | difficulty enjoying sex |
| difficulty breathing | premature climaxing |
| wheezing, shortness of breath | difficulty remembering |
| chest pain | frequent crying |
| arm pain | nervousness |
| jaw pain | insomnia |
| fast heartbeat | depression |
| irregular heartbeats | chemical sensitivity |
| shoulder pain | exposure to toxins |
| blood in vomit | dental fillings/ root canals |
| blood in stool | constipation, diarrhea, pain on defecation |

Family History:

Father: alive deceased cause: _____ age: _____

Mother : alive deceased cause: _____ age: _____

Brother(s): alive deceased cause: _____ age: _____
 alive deceased cause: _____ age: _____

Sisters(s): alive deceased cause: _____ age: _____
 alive deceased cause: _____ age: _____

Illnesses related to blood relative: _____

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Medical History:

What surgeries have you had? When did you have them?

What other serious illnesses have you had?

Please indicate if you have had any of the following, and if so, when and why:

Hospitalizations	[]	Date(s)	_____	Cause(s)	_____
Accidents	[]	Date(s)	_____	Cause(s)	_____
Broken Bones	[]	Date(s)	_____	Cause(s)	_____
Blood Transfusions	[]	Date(s)	_____	Cause(s)	_____
Head Trauma	[]	Date(s)	_____	Cause(s)	_____

Do you have any significant travel history, where you contracted an illness or disease that lasted more than 2 weeks?

Have ever been exposed to any such toxins such as chemicals, paints, radiation, chemotherapy, fumes, dust, solvents, etc.?

If you have ever had the following, please circle accordingly:

- | | | |
|------------------------------|--|-------------------------------|
| Cold Sores | Bleeding Disorder | Peptic Ulcer |
| Asthma | Jaundice | Gastric Ulcer |
| Pneumonia | Hernia | Pancreatitis |
| Respiratory Infection | Thyroid Disorder | History of Smoking |
| Diabetes Mellitus | Warts | History of Drinking Alcohol |
| Diabetes Insipidus | Disorder of the Genitalia | History of Recreational Drugs |
| Emphysema | Gynecological Disorders | History of STD's |
| Scleroderma | Congenital Abnormalities | HIV or Aids |
| Epstein Barr Virus (EBV) | Skin Rashes or Diseases | |
| Cytomegalovirus (CMV) | Cardiac Pacemaker and/or Defibrillator | |
| Lupus Erythmatosis (SLE) | Surgical Implants | |
| Fibromyalgia | Hemorrhoids | |
| Rheumatoid Arthritis | Change in Bowel or Bladder Habits | |
| Osteoarthritis | Blood in Stool | |
| Genital Herpes | Unusual Bleeding or Discharge | |
| Hepatitis A | Peripheral Neuropathy | |
| Hepatitis B | Tinnitus | |
| Hepatitis C | Indigestion | |
| Epilepsy or Seizure Disorder | Colitis | |
| Heart Disease | Chron's Disease | |
| High Blood Pressure | Irritable Bowel Syndrome | |
| Kidney Disease | Gallstones | |
| Cancer | Difficulty swallowing | |
| Rheumatic Fever | Obvious change in a Wart or Mole | |
| Stroke | Cough | |
| Tuberculosis | Hoarsness | |
| Bladder Problem/Infection | Anemia or Other Blood Disorder | |