AcuHeal NOVA

Patient: _____

Male

Today's Date:_____

Medical History Form

Patient Name _____ DOB _____ Age _____

Patient Address _____

Patient City, State, ZIP _____

Patient Email Address _____

Patient Phone (H) _____ (W) _____

Occupation _____ Employer _____

Work Address _____

Work City, State, ZIP _____

Patient Relationship Status _____ Height _____ Weight _____

Partner's Name _____ DOB _____ Phone _____

Family Physician _____ Phone _____

How did you find us? ❒ Word of mouth ❒ Internet ❒ Advertisement

Emergency Contact Info

The name of the person you would like to contact in emergency _____

Phone (H) (_____)_____-_____ Phone (W) (_____)_____-_____ Relationship _____

Have you eaten 2 hours prior to your treatment? ❒ Yes ❒ No *You must eat within 2 hours prior to your treatment.*

Reason for Today's Visit

What is the reason for today's visit? _____

_____

_____

How long have you had this condition? _____

_____

_____

What seemed to be the initial cause? _____

_____

_____

What makes it better or worse? _____

_____

_____

Have you consulted your doctor? _____

_____

_____

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Health History

Check whether you or someone in your family have/ had the condition. Note the year for conditions you have had.

	You (yr)	Family		You (yr)	Family
Cancer	❒ ____	❒	Herpes	❒ ____	❒
- Type(s) _____			AIDS/HIV	❒ ____	❒
Diabetes	❒ ____	❒	Other STD	❒ ____	❒
Hepatitis (A, B, C)	❒ ____	❒	- Type(s) _____		
High Blood Pressure	❒ ____	❒	Rheumatic Fever	❒ ____	❒
Heart Disease	❒ ____	❒	Alcoholism	❒ ____	❒
Stroke	❒ ____	❒	Allergies	❒ ____	❒
Seizure Disorder	❒ ____	❒	- Type(s) _____		
Thyroid Disease	❒ ____	❒	Mental Illness	❒ ____	❒
Asthma	❒ ____	❒	- Type(s) _____		
Pacemaker	❒ ____	❒	Kidney Disease	❒ ____	❒
Osteoporosis	❒ ____	❒	Anemia	❒ ____	❒
Multiple Sclerosis	❒ ____	❒	Thyroid Disorder	❒ ____	❒

Notes: _____

Prescriptions & OTC Drugs

	Dose	Condition
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		

Side effects: _____

Nutraceuticals & Vitamins

	Dose	Condition
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		

Side effects: _____

Exercise

Do you exercise regularly?

Yes ❒ No ❒

If so, what and how often?

_____

_____

_____

_____

Habits

	Amt/Week	If quit, year
Coffee/tea	_____	_____
Soda	_____	_____
Tobacco	_____	_____
Alcohol	_____	_____
Drugs	_____	_____

Surgeries

List what they were for & the date:

_____

_____

_____

_____

_____

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Part A

- Shortness of breath ❒
- Weak voice ❒
- Little or no desire to speak ❒
- Fatigue ❒
- Spontaneous sweating ❒
- Prefer quiet environments with less talking ❒
- Dislike physical activity ❒
- Weakness or lack of strength ❒
- Frequent, small amounts of pale urine ❒

Part B

- Cold, wearing warmer clothes than others ❒
- Cold arms and legs or hands and feet ❒
- Preference for hot drinks ❒
- Wake up at night to urinate ❒
- Frequent, copious amounts of clear/pale urine ❒
- Dislike winter or air conditioned rooms ❒
- Discomfort after eating cold foods ❒
- Symptoms are worse during cold weather ❒
- Tip of the nose is cold ❒
- Absence of thirst ❒

Part C

- Feeling of heat in the afternoon ❒
- Hands and feet get hot ❒
- Heat in the center of the chest, near the heart ❒
- Dry, parched throat, especially at night ❒
- Restless, uneasy, fidgety, agitated ❒
- Cheeks and face get flushed ❒
- Underweight ❒
- Night sweats ❒
- Hot flashes ❒

Part D

- Head spins when standing up ❒
- Numbness of hands and feet ❒
- Dry or brittle skin, hair, or lips ❒
- Brittle or withered nails ❒
- Anxiety ❒
- Loss of balance ❒

Part E

- Bleeding of dark, clotted blood ❒
- Bruises or bleeding under the skin ❒
- Blood clots ❒
- Black or very dark stools ❒
- Spider veins or other visible veins ❒

Part F

- Profuse bleeding of any kind ❒
- Urinate small amounts of dark urine ❒
- Hot-tempered ❒
- Preference for cold drinks ❒
- Very thirsty ❒
- Bitter taste in the mouth all day ❒
- Mouth sores ❒
- Hot, warmer than the people nearby ❒
- Halitosis, bad breath ❒
- Head gets sweaty ❒
- Always hungry ❒
- Foul-smelling stools ❒
- Bleeding gums ❒

Part G

- Heaviness of head or body ❒
- Pain and heaviness in joints ❒
- Stickiness in the mouth ❒
- Fatty bumps under the skin ❒
- Edema or swelling ❒
- Bone growths or deformities ❒
- Feel heavy, slow, or sluggish ❒

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- Runny nose or coughing up phlegm ❒
- Bowel movements contain mucous ❒
- Cloudy urine ❒
- Thirst with no desire to drink ❒

Part H

- Sores on the tongue ❒
- Dream-disturbed sleep ❒
- Difficulty falling asleep, but sleep well ❒
- Angina ❒
- Speech pathology (stutter, lisp, aphasia) ❒
- Hyperactivity, excitability ❒
- Can't think of the word you want to say ❒
- Bitter taste in the mouth in the morning ❒
- Palpitations; heartbeat feels too fast ❒

Part I

- Symptoms that worsen with emotions ❒
- Anger, frustration, bitterness ❒
- Ribside pain ❒
- Frequent sighing ❒
- Feel like a lump is stuck in the throat ❒
- Depression or mood swings ❒
- Stressed out or irritable ❒
- Clumsiness ❒
- Blurred vision or floaters in your vision ❒
- Constipation with bitty stools ❒
- Alternating constipation and diarrhea ❒
- Tinnitus, loud, high-pitched, like a whistle ❒
- Dry eyes ❒

Part J

- Cough ❒
- Sneeze ❒
- Struggling to breathe ❒
- Unexpected sadness ❒
- Asthma ❒
- Catch colds easily ❒
- Swelling of the eyes and face ❒

Part K

- Abdominal bloating ❒
- Lack of appetite ❒
- Worry or excessive thinking ❒
- Prolapsed organ (uterus, bladder, etc.) ❒
- Sweet taste in your mouth ❒
- Watery stools ❒
- Feel sleepy after eating ❒
- Loose stools containing undigested food ❒
- Hemorrhoids ❒
- Poor digestion ❒
- Nausea ❒

Part L

- Diarrhea first thing in the morning ❒
- Brittle or loose teeth ❒
- Weak bones ❒
- Incontinence of urine or stools ❒
- Sore or weak back or knees ❒
- Difficulty inhaling a deep breath ❒
- Premature graying or thinning hair ❒
- Hearing impairment ❒
- Salty taste in the mouth ❒
- Wake up many times during the night ❒
- Tinnitus, low-pitched, like rushing water ❒
- Thirsty, prefer small sips of liquids ❒
- Pressure in the eyes ❒

Part M

- Dizziness ❒
- Constipation ❒
- Bowel movements contain blood ❒
- Painful urination ❒
- Wake early and can't fall asleep again ❒
- Difficult urination ❒
- Seizures ❒

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Additional Health History

Please make an X on the scales and check any boxes of symptoms you have had in the past month. If you would like to add additional information, please do so on the following page.

Temperature

Cold ——— Hot

How warm/cold do you feel (not in degrees); relative to other people do you wear more or fewer layers of clothes, etc.

- ❒ Cold hands or feet
- ❒ Chills
- ❒ Cold "in the bones"
- ❒ Areas of numbness
- ❒ Thirst for hot/cold drinks (circle)
- ❒ Absence of thirst
- ❒ Thirst, but no desire to drink
- ❒ Excessive thirst
- ❒ Night sweats
- ❒ Unusual sweats
  - when _____am/pm
  - where on body _____
- ❒ Hot hands, feet, chest
- ❒ Hot flashes
- ❒ Hot in the afternoon
- ❒ Hot at night

Moisture

Dry ——— Oily

Your overall body moisture (hair, skin, mouth, bowels, etc.)

- ❒ Dry skin
- ❒ Dry hair
- ❒ Dry eyes
- ❒ Dry, brittle nails
- ❒ Dry mouth
- ❒ Dry lips
- ❒ Dry throat
- ❒ Dry nose/nosebleeds
- ❒ Edema/Swelling
- ❒ Rashes
- ❒ Itching
- ❒ Dandruff
- ❒ Oily skin
- ❒ Oily hair
- ❒ Pimples
- ❒ Weight gain/loss

Digestion

Diarrhea ——— Constipation

BM: Freq? ____x/every ____ days

Stools keep shape? yes no

- ❒ Alt. diarrhea & const.
- ❒ Indigestion
- ❒ Gas
- ❒ Bloating
- ❒ Belching
- ❒ Poor appetite
- ❒ Nausea/Vomiting
- ❒ Bad breath
- ❒ Heartburn
- ❒ Excessive hunger
- ❒ Dry stools
- ❒ Stools difficult to pass
- ❒ Tired after BM
- ❒ Foul-smelling stools

Energy

Low ——— High

- ❒ Sudden energy drop
  - Time of day: _____am/pm
- ❒ Energy drop after eating
- ❒ Fatigue
- ❒ Dependence on caff/stimulants
- ❒ Wired/ungrounded feeling
- ❒ Body/limbs feel heavy
- ❒ Body/limbs feel weak
- ❒ Shortness of breath
- ❒ Heart palpitations
- ❒ Blood pressure: high low
- ❒ Bleed/Bruise easily
- ❒ Hard to concentrate
- ❒ Poor memory
- ❒ Dizziness/Lightheaded
- ❒ Headaches: ____x/week

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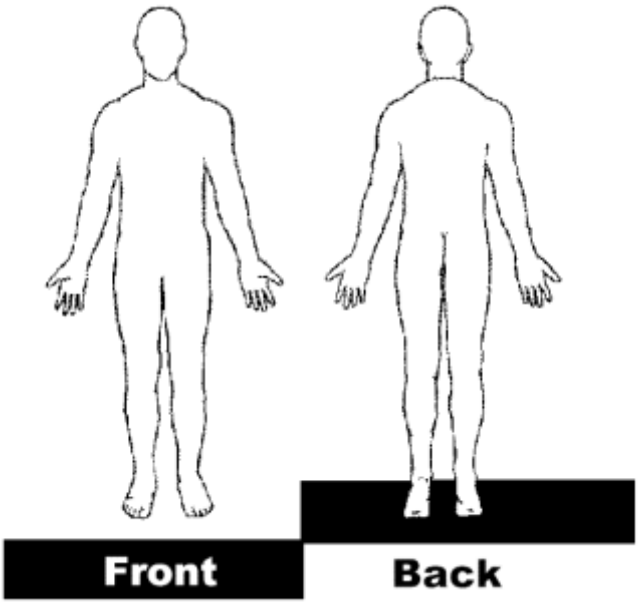
Urinary & Reproductive

Fluid in = fluid out? yes no

- ❒ Urgency to urinate
- ❒ Frequent urination
- ❒ Decrease in flow
- ❒ Dribbling
- ❒ Painful urination
- ❒ Burning sensation
- ❒ Difficulty starting/stopping
- ❒ Incontinence
- ❒ Cloudy urine
- ❒ Kidney stones
- ❒ Blood in urine

- ❒ Change in sex drive
- ❒ Genital pain
- ❒ Erectile dysfunction
- ❒ Jock itch
- ❒ Premature ejaculation
- ❒ Vasectomy
- ❒ Sores on genitals
- ❒ Hernia
- ❒ Discharge
- ❒ Hemorrhoids
- ❒ Prostate disease



Pain & Injuries

Mark the location of any pain &/or injuries on the picture at left. Pain is (check all that apply): Additional information incl. onset date & cause

- ❒ Dull _____
- ❒ Achy _____
- ❒ Sharp _____
- ❒ Stabbing _____
- ❒ Burning _____
- ❒ Fixed _____
- ❒ Moves around _____
- ❒ Radiating _____
- ❒ Other _____ _____

Additional Information