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ENLIVEN
Health and Wellness Center

# Medical History

Confidential

Name_____ Sex M F Age:_____ Today's Date: _____
Address:_____ City:_____ Zip: _____
Home Phone:_____ Business Phone:_____
Birth date:_____
Occupation:_____ Referred by:_____

Have you ever had acupuncture before? Yes/No Are you pregnant? Yes/No
Have you tested positive for the HIV virus? Yes/ No Do you have any surgical implants? Yes/No

Who is your Western Family Doctor?_____ Gynecologist_____
In case of emergency, call…. _____ Telephone _____

Chief Complaint:_____

When did it start/ date of onset? _____
How did it develop? _____
Have you had this in the past? _____
What makes it better? _____
What makes it worse? _____
Is you condition: ____Getting worse ___Constant ___Comes and goes
What treatments have you already received? _____
If yes, when _____
What where the results of your past treatments?_____
_____

Drug, Food or Supplement Allergies

_____
_____
_____
_____

| Medication or Supplement you are currently taking | Dosage | Date Started |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

Please check any family history you might have of the folowing conditions;
☐ Cancer
☐ Heart Disease
☐ Diabetes
☐ Auto-Immune (Lupus, Rheumatoid Arthritis, Hoshimoto's, MS)
☐ Thyroid Diseases

Name:_____ Date:_____

| Medication or Supplement you are currently taking | Dosage | Date Started |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

| Surgeries | When | Comments |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

| Hospitalizations | When | Comments |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

How often have you taken antibiotics

| | Less than 5 times | More than 5 times |
|---|---|---|
| Infancy/childhood | _____ | _____ |
| Teen | _____ | _____ |
| Adult | _____ | _____ |

If your complaint is pain related, please answer the questions below:

Rate the following on a scale of 1 to 10 (0 being no pain and 10 being the most intense pain imaginable):

The pain intensity you are having at this very moment _____
The usual pain intensity you have experienced over the last week _____
How much has your pain interfered with daily activities _____

Rate how often your pain occurs:

| Frequency | Duration |
|---|---|
| ☐ Continuous | ☐ Seconds |
| ☐ Several Times a Day | ☐ Minutes |
| ☐ Once per Day | ☐ Hours |
| ☐ Three times a week | ☐ Days |
| ☐ Once per week | ☐ Continuous |

Description of pain (check any that may apply)…

| | |
|---|---|
| ☐ Throbbing | ☐ Burning |
| ☐ Heavy | ☐ Aching |
| ☐ Gnawing | ☐ Tender |
| ☐ Cramping | ☐ Stabbing |
| ☐ Hot | ☐ Cold |
| ☐ Dull | |