Monique Gaboury L.Ac.
5492 Myrtle Ave, Suite 200
Freeland, WA 98249
360-672-1506

Patient Health History

Name _____Date _____
Address_____
Phone _____ Email_____
Preferred method of communication- voicemail, text, email (circle as many as apply).
Would you like to be added to the mailing list for my blog? (circle one) Yes No
Date of Birth _____ Preferred pronouns _____
Emergency Contact _____ Emergency Contact # _____
Relationship _____ Family Physician _____
Phone _____ Date of Last Physical _____
With whom do you live? _____
What brings you the greatest joy? _____
_____
What is most stressful or dissatisfying in your life currently? _____
_____
Have you been treated with East Asian Medicine/Acupuncture before? If so, for what issue? _____
What are you seeking care for at this time? _____
_____
Date of onset_____ Is it improving or worsening? _____
Have you been diagnosed for this issue? _____
What treatments have you tried for this issue, and what were their outcomes?
_____
_____
Illnesses (current and past) _____
_____
Surgeries (include date) _____
_____

Trauma (physical or emotional) _____

_____

_____

_____

History of infectious disease (current or past) _____

_____

Medications (including herbs, supplements, over the counter, and prescriptions) and for what they are being taken? _____

_____

_____

_____

_____

Describe a typical meal for: Breakfast _____

Lunch _____

Supper _____

Snacks _____

Fluid intake per day (what type and how much)? _____

Exercise (what type)? _____

How many hours per night of sleep? _____ Do you awake rested? _____

What nourishes your spirit? _____

_____

_____

Occupation _____ Occupational hazards_____

What type of support system do you have? _____

_____

_____

Nicotine, alcohol, caffeine, recreational drug use (include how much and how often)?

_____

_____

Family Medical History

Alcoholism_____	Cancer_____	High Cholesterol_____
Asthma_____	Depression_____	Mental Illness_____
Allergies_____	Diabetes_____	Stroke_____
Autoimmune_____	Heart Disease_____	Other_____
Arthritis _____	High Blood Pressure_____	

General Review of Systems (Put a P for Past or C for Current Beside Checked Boxes)

❑ Chills	❑ Strong Thirst	❑ Bruise Easily
❑ Fever	❑ Sudden Energy Drop	❑ Bleed Easily
❑ Night Sweats	❑ Local Weakness	❑ Weight Loss
❑ Sweat Easily	❑ Poor Sleep	❑ Weight Gain
❑ Puffiness/Swelling	❑ Poor Balance	❑ Fatigue
❑ Appetite Changes	❑ Poor Appetite	❑ Tremors
❑ Peculiar Cravings		

Skin and Hair

❑ Rashes	❑ Eczema	❑ Hair Loss
❑ Itching	❑ Psoriasis	❑ Fungal Infections
❑ Skin Ulcers	❑ Acne	❑ Moles
❑ Hives	❑ Dandruff	❑ Other

Head, Eyes, Ears, Nose, Throat

❑ Headaches	❑ Night Blindness	❑ Nosebleeds
❑ Migraines	❑ Color Blind	❑ Taste/Smell Issues
❑ Dizziness	❑ Blind Spots	❑ Teeth Grinding
❑ Concussion	❑ Eye Discharge	❑ Jaw Pain
❑ Poor Vision	❑ Poor Hearing	❑ Recurring Sore Throat
❑ Floaters	❑ Ringing in Ears	❑ Lump in Throat
❑ Cataracts	❑ Ear Ache	❑ Tooth/Gum Issues
❑ Dry Eyes	❑ Ear Discharge	❑ Tongue/Mouth Ulcers
❑ Blurred Vision	❑ Sinus Issues	

Cardiovascular

❑ High Blood Pressure	❑ Chest Pain	❑ TIA/Stroke
❑ Low Blood Pressure	❑ Palpitations	❑ Dizziness
❑ Cold Hands/Feet	❑ Irregular Heartbeat	❑ Fainting
❑ Swelling of Hands/Feet	❑ Heart Attack	❑ Anemia
❑ Varicose Veins	❑ Heart Murmur	❑ Tingling Hands or Feet

Respiratory

❑ Asthma	❑ Painful Breathing	❑ Easily Winded
❑ Cough	❑ Difficulty Breathing	❑ Bronchitis
❑ Phlegm	❑ Coughing Blood	❑ Pneumonia

Gastrointestinal

❑ Bad Breath ❑ Acid Regurgitation ❑ Nausea/Vomiting ❑ Indigestion ❑ Hiccups ❑ Belching ❑ Ulcers ❑ Bloating After Meals	❑ Increased Appetite ❑ Decreased Appetite ❑ Constipation ❑ Gas ❑ Diarrhea ❑ Loose Stools ❑ Blood in Stools ❑ Chronic Laxative Use	❑ Polyps ❑ Irritable Bowel ❑ Inflammatory Bowel ❑ Leaky Gut ❑ Gallstones or Gallbladder Disease ❑ Hemorrhoids ❑ Abdominal Pain

Urinary

Painful Urination Urgency to Urinate Increase/Decrease Output	Cloudy Urine Unable to Hold Urine Bloody Urine	Frequent Urination Frequent Urination at Night Kidney Stones or Disease

Gynecology

❑ PMS ❑ Irregular Periods ❑ Painful Periods ❑ Heavy Flow ❑ Light Flow ❑ Color of Blood_____ ❑ Spotting	❑ Clotting ❑ Uterine Fibroids ❑ Endometriosis ❑ Vaginal Discharge ❑ Vaginal Sores ❑ Vaginal Infections ❑ STD's ❑ Difficulty Conceiving	❑ # of Pregnancies ❑ # of Births ❑ Date of Menopause ❑ Breast Lumps ❑ Nipple discharge ❑ Ovarian Cysts ❑ Hysterectomy ❑ Increase/Decrease Sexual Energy

Men

❑ BPH ❑ Prostate Cancer ❑ Testicular Cancer	❑ STD's ❑ Sexual Difficulties ❑ Increase/Decrease Sexual Energy	❑ Difficulty Conceiving ❑ Penile Discharge

Musculoskeletal

❑ Arthritis ❑ Muscle Spasms ❑ Pain When Weather Changes ❑ Muscle Cramps	❑ Muscle Weakness ❑ Scoliosis ❑ Pain Better with Activity ❑ Pain Better with Rest	❑ Pain Upon Awaking ❑ Major Musculoskeletal Injuries/Problems_____ _____

Endocrine

❑ Hypothyroid ❑ Hyperthyroid	❑ Diabetes ❑ Hypoglycemia	❑ Adrenal Problems ❑ Other_____

Neuropsychological

❑ Seizures ❑ Tremors ❑ Tics ❑ Numbness ❑ Paralysis ❑ Poor Memory ❑ Irritability/Frustration	❑ Sadness/Lack of Joy ❑ Grief ❑ Cyclic Thinking/Worry ❑ Depression ❑ Anxiety ❑ Suicide Attempt ❑ Other_____	❑ Sleep Disorders ❑ Mood Swings ❑ Vertigo ❑ Lack of Balance ❑ Lack of Coordination ❑ Concussion ❑ Substance Abuse ❑ Abuse Survivor

Thank you for your time in filling out your health history. This information is completely confidential and is used as a part of your East Asian Medicine diagnosis and treatment plan.