Adele

Bu Shen Healing

Please Note: This is a confidential record of your medical history and will be kept in this office. Information contained here will not be released to any person except when you have authorized us to do so.

Name M.I. Last Name

Address City State Zip

Phone ( ) Cell ( ) Email

Date Age Date of Birth

Male ☐ Female ☐ Email Address:

Occupation Education

Married ☐ Single ☐ Divorced ☐ Partner ☐ Name of Spouse

Emergency Contact Telephone ( )

Referred by

Goals: What would you most like to achieve through your work here

1.____

2 ____

3 ____

Major Symptoms: Please list in order of importance what symptoms are of concern to you.
(most concerning to least, along with the duration of the symptom)

1____

2 ____

3 ____

Medical History

Please check all that apply	***Date Diagnosed***		***Date Diagnosed***
Diabetes	___ / ___ / ___	High Cholesterol	___ / ___ / ___
High Blood Pressure	___ / ___ / ___	High Blood Pressure	___ / ___ / ___
Thyroid Disease	___ / ___ / ___	Seizures	___ / ___ / ___
Cancer	___ / ___ / ___	Hepatitis	___ / ___ / ___
HIV	___ / ___ / ___	Others	___ / ___ / ___

Surgical History

____ Date

____ Date

____ Date

Family History

Please check all that apply and state how you are related to the family member with that condition.

Condition	Mother	Father	Sibling	Grandparent
Heart disease				
Cancer				
Hypertension				
Stroke				
Asthma				
Allergies				
Migraines				
Depression				
Other mental illness				
Substance abuse				
Osteoporosis				
Diabetes				
Glaucoma				

Medications / Supplements

Medications you are currently taking (please include prescription medicine, supplement, herbal supplements and over the counter medicines you take on a regular basis, along with dosages and brands if known)

_______________ _______________ _______________

_______________ _______________ _______________

_______________ _______________ _______________

Allergies (to medications, chemicals or foods):

_______________ _______________ _______________

_______________ _______________ _______________

Nutrition

Do you follow a special diet? [ ] Yes [ ] No If yes, how would you describe the diet?

(ie Vegetarian, Vegan, Low Carb, etc.)_______________________________

What do you eat on a "typical" day?

Breakfast

____

Lunch

____

Dinner

____

Snacks

____

Foods you tend to crave:

____

Foods you dislike:

____

Social History

1. How much per day/week/month do you use of the following?

a) Coffee, tea, soft drinks:____

b) Alcohol:____

c) Cigarettes, cigars, other tobacco:____

d) Recreational or Other drugs:____

For Women:

Are you pregnant now? [ ]Yes [ ]No [ ]Unsure

Indicate number of occurrences:

Live Births _______ Pregnancies_______ Miscarriages _______ Abortions _______

Age: First period _____ Menopause (if applicable) _____

Date: Last Pap Smear _____ /_____ Last Mammogram _____ / ______

Any History of an Abnormal Pap Smear? [ ] Yes [ ] No If so, what / when?

____

For Men:

Do you have any bothersome urinary symptoms? [ ] Yes [ ] No

Describe:____

Exercise

Please describe your current exercise regimen:

Hours per week: ______ Activities: ____ [ ] No Exercise

Sleep

How many hours of sleep do you usually get per night during the week? _____________

Do you awake feeling rested? [ ] Yes [ ] No Do you feel you sleep well at night? [ ] Yes [ ] No

Other Information

Please list and briefly describe any other information that might be important

.____

____

____

____

HEALTH: CHECK ALL THAT APPLY

GENERAL

Past	Current	Condition
[ ]	[ ]	Poor appetite
[ ]	[ ]	Excessive appetite
[ ]	[ ]	Insomnia
[ ]	[ ]	Fatigue
[ ]	[ ]	Fevers
[ ]	[ ]	Night sweats
[ ]	[ ]	Sweat easily
[ ]	[ ]	Chills
[ ]	[ ]	Localized weakness
[ ]	[ ]	Poor coordination
[ ]	[ ]	Bleed or bruise easily
[ ]	[ ]	Catch cold easily
[ ]	[ ]	Change in appetite
[ ]	[ ]	Strong thirst
[ ]	[ ]	Other: _______________

SKIN & HAIR

Past	Current	Condition
[ ]	[ ]	Rashes
[ ]	[ ]	Hives
[ ]	[ ]	Itching
[ ]	[ ]	Eczema
[ ]	[ ]	Pimples
[ ]	[ ]	Dryness
[ ]	[ ]	Tumors, lumps
[ ]	[ ]	Hair loss

HEAD & NECK

Past	Current	Condition
[ ]	[ ]	Dizziness
[ ]	[ ]	Fainting
[ ]	[ ]	Neck stiffness
[ ]	[ ]	Enlarged lymph glands
[ ]	[ ]	Headaches
[ ]	[ ]	Concussions
[ ]	[ ]	Other: _______________

EARS

Past	Current	Condition
[ ]	[ ]	Infection
[ ]	[ ]	Ringing
[ ]	[ ]	Decreased hearing
[ ]	[ ]	Other: _______________

EYES

Past	Current	Condition
[ ]	[ ]	Blurred vision
[ ]	[ ]	Visual changes
[ ]	[ ]	Poor night vision
[ ]	[ ]	Spots
[ ]	[ ]	Cataracts
[ ]	[ ]	Glasses / contacts
[ ]	[ ]	Eye inflammation
[ ]	[ ]	Other: _______________

NOSE, THROAT, MOUTH

Past	Current	Condition
[ ]	[ ]	Nose bleeds
[ ]	[ ]	Sinus infections
[ ]	[ ]	Hay fever or allergies
[ ]	[ ]	Recurring sore throats
[ ]	[ ]	Grinding teeth
[ ]	[ ]	Difficulty swallowing

CARDIOVASCULAR

Past	Current	Condition
[ ]	[ ]	High blood pressure
[ ]	[ ]	Low blood pressure
[ ]	[ ]	Blood clots
[ ]	[ ]	Palpitations
[ ]	[ ]	Phlebitis
[ ]	[ ]	Chest pain
[ ]	[ ]	Irregular heart beat
[ ]	[ ]	Cold hands / feet
[ ]	[ ]	Fainting
[ ]	[ ]	Difficult breathing
[ ]	[ ]	Swelling of hands / feet
[ ]	[ ]	Other: _____________

RESPIRATORY

Past	Current	Condition
[ ]	[ ]	Asthma
[ ]	[ ]	Bronchitis
[ ]	[ ]	Frequent colds
[ ]	[ ]	Chronic obstructive
[ ]	[ ]	Pulmonary disease
[ ]	[ ]	Pneumonia
[ ]	[ ]	Cough
[ ]	[ ]	Coughing blood
[ ]	[ ]	Production of phlegm
[ ]	[ ]	Other: ______________

GASTRO-INTESTINAL

Past	Current	Condition
[ ]	[ ]	Nausea
[ ]	[ ]	Vomiting
[ ]	[ ]	Diarrhea
[ ]	[ ]	Belching
[ ]	[ ]	Blood in stools/black
[ ]	[ ]	Stools
[ ]	[ ]	Bad breath
[ ]	[ ]	Rectal pain
[ ]	[ ]	Hemorrhoids
[ ]	[ ]	Constipation
[ ]	[ ]	Pain or cramps
[ ]	[ ]	Indigestion
[ ]	[ ]	Gall bladder disorder
[ ]	[ ]	Gas
[ ]	[ ]	Bloating
[ ]	[ ]	Acid Reflux / GERD

GENITO-URINARY

Past	Current	Condition
[ ]	[ ]	Kidney stones
[ ]	[ ]	Painful urination
[ ]	[ ]	Frequent urination
[ ]	[ ]	Blood in urine
[ ]	[ ]	Urgency to urinate
[ ]	[ ]	Unable to hold urine
[ ]	[ ]	Night Urination
[ ]	[ ]	Other: ______________

MALE

Past	Current	Condition
[ ]	[ ]	Pain / itching genitalia
[ ]	[ ]	Genital lesions/ discharge
[ ]	[ ]	Impotence
[ ]	[ ]	Weak urinary stream
[ ]	[ ]	Lumps in testicles
[ ]	[ ]	Other: ______________

FEMALE

Past	Current	Condition
[ ]	[ ]	Frequent urinary tract infections
[ ]	[ ]	Frequent vaginal infections
[ ]	[ ]	Pain / itching of genitalia
[ ]	[ ]	Genital lesions / discharge
[ ]	[ ]	Pelvic inflammatory disease
[ ]	[ ]	Abnormal pap smear
[ ]	[ ]	Irregular menstrual periods
[ ]	[ ]	Painful menstrual periods
[ ]	[ ]	Premenstrual syndrome
[ ]	[ ]	Abnormal bleeding
[ ]	[ ]	Menopausal Syndrome
[ ]	[ ]	Breast lumps
[ ]	[ ]	Hot flashes
[ ]	[ ]	Other: _____________

NEUROLOGICAL

Past	Current	Condition
[ ]	[ ]	Seizures
[ ]	[ ]	Tremors/Motor Ticks
[ ]	[ ]	Numbness/tingling of limbs
[ ]	[ ]	Concussion
[ ]	[ ]	Pain
[ ]	[ ]	Paralysis
[ ]	[ ]	Other: __________________

PSYCHOLOGICAL

Past	Current	Condition
[ ]	[ ]	Depression
[ ]	[ ]	Anxiety / stress
[ ]	[ ]	Irritability
[ ]	[ ]	Treated for emotional or
[ ]	[ ]	Psychological problems
[ ]	[ ]	Other: __________________

INFECTION SCREENING

Past	Current	Condition
[ ]	[ ]	HIV
[ ]	[ ]	TB
[ ]	[ ]	Hepatitis
[ ]	[ ]	Gonorrhea
[ ]	[ ]	Chlamydia
[ ]	[ ]	Syphilis
[ ]	[ ]	Genital warts
[ ]	[ ]	Herpes: oral
[ ]	[ ]	Herpes: genital

MUSCULAR-SKELETAL

Past	Current	Condition
[ ]	[ ]	Stiff neck / shoulders
[ ]	[ ]	Low back pain
[ ]	[ ]	Back pain
[ ]	[ ]	Muscle spasm, twitching, cramps
[ ]	[ ]	Sore, cold or weak knees
[ ]	[ ]	Joint pain
[ ]	[ ]	Hernia