Glynn Pellagrino, Lic. Ac

Acupuncture &
Traditional Chinese Medicine

CONFIDENTIAL HEALTH HISTORY

Dear Patient:

This information is considered confidential. We need this information because we care enough to want to know, and your answers will help us determine if Holistic Health Care can help you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case. In order for us to understand your condition properly, please be as neat and accurate as possible while completing this form. Thank you.

PERSONAL:

Name _____ Sex_____
Marital Status_____
Date of Birth _____
Home Phone_____
Business Phone_____
Cell Phone_____
Email Address_____
Address_____
Occupation_____
Social Security Number_____
Place of Work_____

HEALTH REPORT:

Height: Feet____ Inches____Weight____

What is your main complaint?_____
_____
_____
(Health Report,

Condition is worst (time of day) AM_____ PM_____

Position: standing_____walking_____sitting_____lying down_____contstantly_____

Have you had any treatment for this condition? yes_____no_____

If yes, list treatments:_____
_____

Have you seen a chiropractor or acupuncturist in the past? yes_____no_____
If yes, for what condition were you treated?_____
Where did you receive treatment?_____
How many times did you receive treatment?_____
What were the best things about your treatment?_____
In what ways could your treatment have been improved?_____
Additional Comments: _____
_____

Are you taking any medications currently? yes_____no_____
If yes, please list: _____
Do you regularly take any vitamin or other nutritional supplements? yes_____no_____
If yes, please list: _____

Do you smoke? yes_____no_____

Have you been treated for any health condition by a physician in the last year?
yes_____no_____
If yes, please explain: _____
Please list the approximate date of any surgery or unusual disease you have had.
_____

Are you a vegetarian? yes_____no_____

Are you allergic to any substances? yes_____no_____
If yes, please list: _____

Are you or do you have any reason to believe you are pregnant?yes_____no_____

(Health Report, continued)

PLEASE LIST THE APPROPRIATE LETTER FOR ANY OF THE FOLLOWING SYMPTOMS WHICH YOU HAVE NOW OR HAVE HAD PREVIOUSLY

O=Occasional
F=Frequent
O=Constant

GENERAL
__ Allergy
__Convulsions
__Dizziness
__Fainting
__Fatigue
__Fever
__Headache
__Loss of Sleep
__Loss of weight

__Nervousness/ Depression
__Neuralgia
__Numbness
__Sweats
__Tremors

Muscle & Joint
__ Arthrits
__ Bursitis
__Foot trouble
__Hernia
__Low Back Pain
__Neck Pain or Stiffness
__Pain between shoulders
Pain or numbness in:
__Shoulders

__Arms
__Elbows
__Hips
__Legs
__Knees
__Feet
__Painful tailbone
__Poor Posture
__Sciatica
__Spinal curvature

Gastro-intestinal
__Belching or Gas
__ Colitis
__Colon Trouble
__ Constipation
__Diarrhea
__Difficult digestion
__Distension of abdomin
__Excessive Hunger
__Gall bladder trouble
__Hemorrhoids
__Intestinal worms
__Jaundice
__Liver trouble
__Nausea
__ Poor Appetite
__Vomiting
__Vomiting blood

PLEASE LIST THE APPROPRIATE LETTER FOR ANY OF THE FOLLOWING SYMPTOMS WHICH YOU HAVE NOW OR HAVE HAD PREVIOUSLY

O=Occasional
F=Frequent
O=Constant

Eyes, Ears, Nose and Throat

__Asthma __Colds __Deafness __Earache __Ear Discharge __Ear Noises __Enlarged Glands __ Enlarged Thyroid __Eye Pain __Failing vision __Gum Trouble __Hoarseness __Nasal obstruction __Nose bleeds __Sinus infection __Sore throat __ Tonsillitis

Cardio-vasular

__Hardening of the arteries __High Blood Pressure __Low blood pressure __Pain over heart __Poor circulation __Rapid Heart Beat __Slow heart beat __Swelling of the ankles

Respiratory

Chest pain __Chronic cough __Difficulty breathing __Spitting up blood __Spitting up phlegm __Wheezing

Skin

__Bruise easily __Dryness __Hives or allergy __Skin eruptions (rash) __Variocse veins

Genitourinary

__Bed-wetting __Blood in urine __Frequent Urination __Inability to control kidneys __Kidney infections or stones __Painful urination __Prostate trouble __Pus in urine

For Women Only

__Congested breasts __Cramps of backache __Excessive menstrual flow __Hot flashes __Irregular cycle __Menopausal symptoms __Painful menstruation __Vaginal discharge __Yeast Infections

CHECK THE FOLLOWING CONDITIONS IF YOU HAVE HAD THEM

__Alcholism __Anemia __Appendicitis __Arteriosclerosis __Arthritis __Bleeding Disorder __Cancer __Chorea __Cold sores Coronavirus or Covid 19 __Diabetes __Diptheria __Drug dependency __Eczema __Emphysema __Eating disorder __Epilepsy __Fever blisters __Goiter __Gout__Heart disease__Herpes __HIV Positive or exposure __Influenza __Malaria __Measles __Measles __Miscarriage __Multiple sclerosis __Mumps __Pleurisy __Pneumonia __Polio __Rheumatic fever __Scarlet Fever __Stroke __Tuberculosis __Typhoid Fever __Ulcers __Venereal Disease __Whooping cough__ Hepatitis, A,B,C.

IF YOU HAVE INSURANCE COVERAGE WE WILL PROCESS YOUR CLAIM, BUT YOU MUST COLLECT FROM YOUR INSURANCE COMPANY.

BY SIGNING THIS FORM I INDICATE THAT I UNDERSTAND THAT ALL TREATMENTS AND EXPENSES ASSOCIATED WITH TREATMENTS ARE TO BE PAID FOR AS THEY ARE RECEIVED OR DEFINITE FINANCIAL ARRANGEMENTS MADE IN ADVANCE.

Patient Name, Printed:

_____

Patient Signature:

_____

Date: _____

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