**Ren Dao Wellness Center**
**Holistic Counseling Health History – Part One**

This is a confidential questionnaire to help us determine the best place to start sessions. Please write clearly. Thank you.

## Personal Information

Name: Date:

Home Address:

City: State: Zip Code:

Best Contact Number: Cell ☐ Home ☐ Work ☐

Email address: Receive email updates and newsletter: ☐

Occupation: Hours of work per week?

Name of person to contact in case of emergency: Phone:

Who should we thank for referring you to the office?

## Health History

Sex: ☐ Male ☐ Female Birthday: Age: Time of Birth? ☐am ☐ pm

Height: Weight: Place of Birth?

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed Number of children?

How is the health of your mother?

How is the health of your father?

How is the health of your Siblings?

Please indicate any significant illnesses you or your relatives (Parent or sibling) have had:

| | You | Your Relative | Approx Date | | You | Your Relative | Approx Date |
|---|---|---|---|---|---|---|---|
| Cancer | ☐ | ☐ | | Diabetes | ☐ | ☐ | |
| Asthma | ☐ | ☐ | | Heart Disease | ☐ | ☐ | |
| High Blood Pressure | ☐ | ☐ | | Seizures | ☐ | ☐ | |
| High Cholesterol | ☐ | ☐ | | Emotional Disorders | ☐ | ☐ | |
| Stroke | ☐ | ☐ | | Substance Use Disorder | ☐ | ☐ | |

Other Illnesses or health issues:

Blood Type? Sexually Transmitted Diseases: ☐

List any medications and supplements you are currently taking. Continue on back if necessary.

| Medicine / Supplements | Reason | How long |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

*Please enter the use and frequency of the following:*

☐ Tobacco #cigarettes/packs per day ☐ Stopped Date:

☐ Caffeine #coffees/day #teas /day #colas/day

☐ Alcohol #drinks per week

☐ Marijuana ☐ Drugs ☐ Occupational Hazards ☐ Stress

☐ Water Intake # cups per day Prefer: ☐ Cold ☐ Room Temperature ☐ Warm

## For Women

Age of 1st period (menarche): ____ Are you pregnant? ☐ Yes Number of pregnancies: ____
Age of last period (menopause): ____ #of live births: ____ #of abortions: ____ #of miscarriages: ____
Number of days between periods: ____ ☐ Regular ☐ Irregular ____
Color of flow: ____ Clots? ☐ Yes Color: ____
Have you been diagnosed with: ☐ Fibroids ☐ Fibrocystic Breasts ☐ Endometriosis ☐ Ovarian Cysts ☐ PID Other
Location of Pain: ☐ Lower abdomen ☐ Lower back ☐ Thighs ☐ Other
Nature of Pain (Please indicate Before, During or After menses) Other Symptoms related to menses

| | | | | |
|---|---|---|---|---|
| ☐ Cramping | ☐ Stabbing | ☐ Discharge | ☐ Vaginal dryness | ☐ Headache |
| ☐ Burning | ☐ Aching | ☐ Nausea | ☐ Constipation | ☐ Diarrhea |
| ☐ Dull | ☐ Bloating | ☐ Swollen breasts | ☐ Mood Swings | ☐ Ravenous Apetite |
| ☐ Consistent | ☐ Intermittent | ☐ Poor appetite | ☐ Hot flashes | ☐ Night sweats |
| ☐ Bearing down sensation | | ☐ Increased libido | ☐ Decreased libido | ☐ Insomnia |

## For Men

Date of last prostate check up: ____ PSA level: ____
Frequency of urination: Daytime: ____ Nighttime: ____ Color of urine: ☐ clear ☐ murky ☐ dark. Odor ☐
**Related Symptoms:**

| | | | | |
|---|---|---|---|---|
| ☐ Prostrate problems | ☐ Delayed stream | ☐ Dribbling | ☐ Incontinence | ☐ Retention of urine |
| ☐ Erectile Dysfunction | ☐ Increased libido | ☐ Decreased libido | ☐ Premature ejaculation | ☐ Impotence |
| ☐ Back pain | ☐ Groin pain | ☐ Testicular pain | ☐ Other | |

## Symptom Survey (for Everyone)

*Please check any of the following conditions you currently have or have had in the past.*

| | | | |
|---|---|---|---|
| ☐ lack of appetite | ☐ abdominal pain | ☐ eye problems | ☐ fatigue |
| ☐ excessive appetite | ☐ chest pain | ☐ jaundice (yellowish eyes or skin) | ☐ edema |
| ☐ loose stool or diarrhea | ☐ sciatic pain | | ☐ blood in stool |
| ☐ indigestion | ☐ headaches | ☐ difficult digesting oily foods | ☐ black tarry stool |
| ☐ vomiting | ☐ pain or coldness in the genital area | | ☐ easily bruised |
| ☐ belching, burping | | ☐ gall stones | ☐ difficult to stop bleeding |
| ☐ heartburn / reflux | | ☐ light colored stool | ☐ asthma |
| ☐ feeling of retention of food in stomach | ☐ cough | ☐ soft brittle nails | ☐ tendency to catch colds easily |
| ☐ tendency to become obsessive in work or relationships | ☐ decrease sense of smell | ☐ easily angered or agitated | ☐ intolerance to weather changes |
| | ☐ nasal problems | ☐ difficulty in making plans or decisions | ☐ allergies |
| | ☐ skin problems | | ☐ hay fever |
| | ☐ feeling of claustrophobia | ☐ spasms or twitching of muscles | ☐ dizziness |
| ☐ insomnia, difficulty sleeping | ☐ bronchitis | | ☐ high cholesterol level |
| ☐ heart palpitation | ☐ colitis or diverticulitis | ☐ lower back pain | ☐ sudden weight loss |
| ☐ cold hand and feet | ☐ constipation | ☐ knee problems | ☐ urinary problems |
| ☐ nightmares | ☐ hemorrhoids | ☐ hearing impairment | |
| ☐ laughing for no apparent reason | ☐ recent use of antibiotics | ☐ ear ringing | |
| | | ☐ kidney stones | |
| ☐ angina pain | | ☐ hair loss | |

Current weight: ____ Six months ago: ____ One year ago: ____ Five years ago: ____ Ten years ago: ____
Would you like your weight to be different? ____ If so, what? ____
Do you sleep well? Yes: ☐ No: ☐ Do you wake up nights? ☐ What times? ____ How often? ____ To urinate? Yes: ☐
What time do you generally go to bed? ____ What time do you get up in the morning? ____
What role does exercise play in your life? ____
Type: ____ Frequency: ____
Type: ____ Frequency: ____
Please list any healers, helpers, or therapies with which you are involved?

**Ren Dao Wellness Center**
**Holistic Counseling Health History – Part Two**

## Present and Past Diet History

What are your current food choices like these days?

| | |
|---|---|
| Breakfast: | |
| Lunch: | |
| Dinner: | |
| Snacks: | |
| Liquids: | |

What about a year ago?

| | |
|---|---|
| Breakfast: | |
| Lunch: | |
| Dinner: | |
| Snacks: | |
| Liquids: | |

What foods did you eat often as a child?

| | |
|---|---|
| Breakfast: | |
| Lunch: | |
| Dinner: | |
| Snacks: | |
| Liquids: | |

**Ren Dao Wellness Center**
**Holistic Counseling Health History – Part Three**

## Current Health Concerns

What are the main health concerns for which you are seeking treatment?

What other forms of treatment have you sought?

List any other health concerns you now have?

List any allergies, food sensitivities or food craving that you have?

List any accidents, surgeries, or hospitalizations (include dates).

Lab Results: (please include copies)

**Clinical Notes**
(For Acupuncturist Use)

How do you feel about the following areas of your life?
*Please check the appropriate boxes and indicate any problems you may be experiencing.*

| | Great | Good | Fair | Poor | Bad | Your Comments |
|---|---|---|---|---|---|---|
| Significant other | ☐ | ☐ | ☐ | ☐ | ☐ | |
| Family | ☐ | ☐ | ☐ | ☐ | ☐ | |
| Diet | ☐ | ☐ | ☐ | ☐ | ☐ | |
| Sex | ☐ | ☐ | ☐ | ☐ | ☐ | |
| Work | ☐ | ☐ | ☐ | ☐ | ☐ | |
| Exercise | ☐ | ☐ | ☐ | ☐ | ☐ | |
| Stress | ☐ | ☐ | ☐ | ☐ | ☐ | |