Nikol Angel, LAc.
at Laughing Mountain
Invigorating Vitality

Patient Health History

Name: _____ Date: _____/_____/_____
(first) (middle) (last)

Date of Birth: _____/_____/_____ Age: _____ Gender: M/F Marital status: S M D W

Phone:_____ Email:_____ Children (quantity/age):

Mailing Address:_____

1. Please identify the health concerns that have brought you here in order of importance below:

Condition	**Past Course of Treatment**
a. _____	_____
Please rate how this condition affects you:	1 2 3 4 5 6 7 8 9 10
b. _____	_____
Please rate how this condition affects you:	1 2 3 4 5 6 7 8 9 10
c. _____	_____
Please rate how this condition affects you:	1 2 3 4 5 6 7 8 9 10
d. _____	_____
Please rate how this condition affects you:	1 2 3 4 5 6 7 8 9 10

2. When and where did you last receive health care?

_____

For what reason?

_____

3. Have you experienced any major Traumas/Accidents? Y N Work related?_____ Auto related?_____

Date:___/___/___

Specify:_____

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Date:___/___/___

Specify:_____

Date:___/___/___

Specify:_____

4. Has your case been referred to an attorney? Y N

5. **Hospitalizations and Surgeries:**

Reason	When	Reason	When
_____		_____	
_____		_____	
_____		_____	

6. **X-Rays/CAT Scans/MRI's/NMR's/Special Studies:**

Reason	When	Reason	When
_____		_____	
_____		_____	
_____		_____	

Please list any medications (prescribed and over-the-counter), vitamins, and supplements you are currently taking:

_____

_____

_____

If applicable, please list any medications you are hypersensitive or allergic to (please include reaction):

_____

7. Do you have any infectious diseases? Y N If yes, please identify: _____

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8. **Height:** _____ **Weight:** Currently: _____ Past Maximum: _____ When? _____

9. **Blood Pressure:** What is your most recent blood pressure reading? _____/_____ When was this reading taken? _____

10. **Review of Systems**
(please circle any that you experience now and underline any that you have experienced in the past):

A. **Emotional:**

Anxiety Irritability Mood Swings Nervousness Depression Mental Tension

B. **Energy and Immunity:**

Fatigue Slow Wound Healing Chronic Infections Chronic Fatigue Syndrome

C. **Head, Eye, Ear, Nose, & Throat**:

Impaired Vision	Eye Pain/Strain	Glaucoma	Glasses/Contacts	Tearing/Dryness
Impaired Hearing	Ear Ringing	Earaches	Headaches	Sinus Problems
Nose Bleeds	Frequent Sore Throats	Teeth Grinding	TMJ/Jaw Problems	Hay Fever

D. **Respiratory**:

Pneumonia	Frequent Common Colds	Difficulty Breathing	Emphysema
Persistent Cough	Pleurisy	Asthma	Tuberculosis
Shortness of Breath	Other Respiratory Problems: _____		

E. **Cardiovascular:**

Heart Disease	Chest Pain	Swelling of Ankles	High Blood Pressure	
Palpitations/Fluttering	Stroke	Heart Murmurs	Rheumatic Fever	Varicose Veins

F. **Gastrointestinal:**

Ulcers	Changes in Appetite	Nausea/Vomiting	Epigastric Pain	Passing Gas	Heartburn
Belching	Gall Bladder Disease	Liver Disease	Hepatitis B or C	Hemorrhoids	Abdominal Pain

G. **Genito-Urinary Tract:**

Kidney Disease	Painful Urination	Frequent UTI	Frequent Urination	Heavy Flow
Kidney Stones	Impaired Urination	Blood in Urine	Frequent Urination at Night	

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H. **Female Reproductive/Breasts:**

Irregular Cycles	Breast Lumps/Tenderness	Nipple Discharge	Heavy Flow
Vaginal Discharge	Premenstrual Problems	Clotting	Bleeding Between Cycles
Menopausal Symptoms	Difficulty Conceiving	Painful Periods	

Do you have any reason to believe you may be pregnant? Y N If so, how far along are you?_____

I. **Menstrual/Birthing History:**

1. Age of First Menses: _____	4. Birth Control Type: _____	7. # of Abortions: _____
2. # of Days of Menses: _____	5. # of Pregnancies: _____	8. # of Live Births: _____
3. Length of Cycle: _____	6. # of Miscarriages: _____	

J. **Male Reproductive**:

Sexual Difficulties	Prostrate Problems	Testicular Pain/Swelling	Penile Discharge

K. **Musculoskeletal**:

Neck/Shoulder Pain	Muscle Spasms/Cramps	Arm Pain	Upper Back Pain	Mid Back Pain
Low Back Pain	Leg Pain	Joint Pain (if so, where?): _____		

L. **Neurologic**:

Vertigo/Dizziness	Paralysis	Numbness/Tingling	Loss of Balance	Seizures/Epilepsy

M. **Endocrine**:

Hypothyroid	Hypoglycemia	Hyperthyroid	Diabetes Mellitus	Night Sweats	Feeling Hot or Cold

N. **Other**:

Anemia	Cancer	Rashes	Eczema/Hives	Cold Hands/Feet	Psoriasis

Is there anything else we should know? _____

_____

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11. **Lifestyle:**

a. Do you typically eat at least three meals per day? Y N If no, how many?

b. Do you have any food intolerances/ allergies? _____

c. How many glasses caffeinated beverages do you drink per day? Tea_____ Coffee_____ Soda_____

d. Nicotine:_____ Alcohol:_____ Marijuana Use: _____

e. How many hours per night do you sleep? _____ Do you wake rested? Y N

f. Exercise routine: _____

g. Spiritual practice: _____

h. Occupation: _____ Employer: _____ Hours/Week: _____

i. Do you enjoy work? Y/N Why/Why not?

_____

HOW DID YOU HEAR ABOUT US?

_ _

WOULD YOU LIKE TO RECEIVE OUR EMAIL NEWSLETTER?

_ _

STAY INFORMED AND "LIKE" LAUGHING MOUNTAIN ON

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