



Jade Mountain Medicine Patient Health History

Date _____

Name _____
(First) (Last)

Date of Birth _____

Street Address _____

City _____ State _____ Zip Code _____

Home Phone _____ Work Phone _____

Emergency Contact _____

Phone _____ Relationship _____

E-mail: _____

Are you currently receiving health care? Y N

If yes, where and from whom? _____

Condition

Past Treatment

a. _____

How does this condition affect you? _____

b. _____

How does this condition affect you? _____

c. _____

How does this condition affect you? _____

d. _____

How does this condition affect you? _____

Please list any prescription medications, over-the-counter medications, vitamins, and supplements that you are currently taking: (add a page if necessary)



Height _____ Weight _____ Past Max. Weight _____ When? _____

Blood Pressure: What is your most recent blood pressure reading? _____

When was this taken? _____

Do you have any reason to believe that you are pregnant? Y N

Do you have any infectious diseases? Y N If yes, please explain:

Are you currently suffering from any chronic illness? Y N If yes, please explain:

If applicable, please list any foods, drugs, or medications you are hypersensitive or allergic to (please include any type of reaction)

General Condition

Energy Level: ☐ Low ☐ High ☐ Erratic ☐ Loss of Energy ☐ Other

Any tendency to faint, bruise or bleed easily? Y N

Hospitalizations and Surgeries

Reason	When	Reason	When
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_____	_____	_____	_____
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_____	_____	_____	_____
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_____	_____	_____	_____
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X-rays / CAT Scans? MRIs / NMRs / Special Studies? (add page if necessary)

Reason	When	Reason	When
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_____	_____	_____	_____
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_____	_____	_____	_____
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_____	_____	_____	_____
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FAMILY HISTORY — Mother Father Brothers Sisters Spouse Children

Age (if living) _____

Health
(G=good, P=poor) _____

Age at death
(if deceased) _____

Cause of death _____

Lifestyle

Please indicate typical food intake:

Breakfast _____

Lunch _____

Dinner _____

Snacks _____

Daily Exercise _____

Sleep Habits _____

Education _____

Occupation _____ Employer _____

Hrs./wk. _____

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

Nicotine / Alcohol / Caffeine use _____

Have you experienced any major traumas? Y N

Explain _____

Consumption of Liquids _____

Television Habits _____

Reading Habits _____

Interests and Hobbies _____



GENERAL SYMPTOMS

- ☐ Tremors
- ☐ Headache
- ☐ Fever
- ☐ Sweats
- ☐ Fainting
- ☐ Dizziness
- ☐ Convulsions
- ☐ Loss of sleep
- ☐ Fatigue
- ☐ Nervousness
- ☐ Depression
- ☐ Loss of weight
- ☐ Forgetfulness
- ☐ Numbness or pain in arms, hands, elbows, shoulder, hips, legs, knees, or feet
- ☐ Confusion
- ☐ Auto Immune Deficiency
- ☐ Paralysis

EAR, NOSE & THROAT

- ☐ Failing vision
- ☐ Nearsighted
- ☐ Eye pain
- ☐ Eye strain
- ☐ Cross-eyed
- ☐ Eye inflammation
- ☐ Glaucoma
- ☐ Deafness
- ☐ Earache
- ☐ Loss of hearing
- ☐ Ear discharge
- ☐ Ear noises
- ☐ Nose bleeds
- ☐ Nasal obstruction
- ☐ Nasal drainage
- ☐ Loss of smell
- ☐ Sinus infection
- ☐ Hay fever
- ☐ Allergies
- ☐ Sore throat
- ☐ Hoarseness
- ☐ Difficult speech
- ☐ Difficult swallowing
- ☐ Loss of taste
- ☐ Change in tastes
- ☐ Dental decay
- ☐ Gum troubles
- ☐ Tonsillitis
- ☐ Asthma
- ☐ Enlarged thyroid

SKIN

- ☐ Skin eruptions
- ☐ Clammy Skin
- ☐ Dryness
- ☐ Bruise easily
- ☐ Boils
- ☐ Rashes

- ☐ Sensitive skin
- ☐ Hives or allergy

RESPIRATORY

- ☐ Chronic cough
- ☐ Spitting up phlegm
- ☐ Spitting up blood
- ☐ Chest pain
- ☐ Difficult breathing
- ☐ Wheezing

CARDIOVASCULAR

- ☐ Rapid beating heart
- ☐ Slow beating heart
- ☐ Irregular beating heart
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Pain over heart
- ☐ Previous heart stroke
- ☐ Hardening of arteries
- ☐ Swelling of ankles
- ☐ Poor circulation
- ☐ Paralytic stroke
- ☐ Varicose veins

MUSCLE & JOINT

- ☐ Stiff neck
- ☐ Pain between shoulders
- ☐ Backache
- ☐ Painful tail bone
- ☐ Foot trouble
- ☐ Hernia
- ☐ Spinal curvature
- ☐ Faulty posture
- ☐ Swollen joints
- ☐ Stiff joints
- ☐ Painful joints
- ☐ Arthritis
- ☐ Sore muscles
- ☐ Weak muscles
- ☐ Walking problems
- ☐ Sciatica

GENITOURINARY

- ☐ Frequent urination
- ☐ Scanty urine
- ☐ Painful urination
- ☐ Pus in urine

- ☐ Bed wetting
- ☐ Inability to control urine
- ☐ Bladder trouble
- ☐ Foul smelling urine
- ☐ Discolored urine

GASTROINTESTINAL

- ☐ Poor appetite
- ☐ Excessive hunger
- ☐ Difficult chewing
- ☐ Belching or gas
- ☐ Nausea
- ☐ Gas
- ☐ Vomiting
- ☐ Vomiting of blood
- ☐ Pain over stomach
- ☐ Distention of abdomen
- ☐ Constipation
- ☐ Diarrhea
- ☐ Black stool
- ☐ Blood in stool
- ☐ Colon trouble
- ☐ Hemorrhoids (piles)
- ☐ Intestinal worms
- ☐ Liver trouble
- ☐ Gall bladder trouble
- ☐ Jaundice
- ☐ Colitis
- ☐ Weight trouble

FEMALE

- ☐ Painful menstrual periods
- ☐ Excessive flow
- ☐ Hot flashes
- ☐ Irregular cycle
- ☐ Cramps or backache
- ☐ Previous miscarriage
- ☐ Vaginal discharge
- ☐ Vaginal pain
- ☐ Congested breast
- ☐ Breast pain
- ☐ Lumps in breast
- ☐ Menopausal symptoms
- ☐ Abnormal bleeding
- ☐ Reduced sexual energy
- ☐ Pregnancy
- ☐ Pregnancy complications

MALE

- ☐ Pain associated with genitals
- ☐ Reduced sexual energies
- ☐ Premature ejaculation
- ☐ Seminal emission
- ☐ Impotence