

Acupuncture • Herbal Medicine • Massage • Yoga *and so much more!*

Kali Sampson-Alexander, LAc, MTOM

4307 S. Crenshaw Blvd.

Los Angeles, CA 90008

323.295.6887 or 323.29-LOTUS

**HEALTH HISTORY FORM**

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

*By providing complete and detailed information of your health history, you help to **significantly** increase positive outcomes in your treatment. Answer all questions even if you have encountered the same or similar questions in this or previous forms. In holistic medicine we treat the root and the branch—the underlying cause of disease as well as the symptoms or expression. Therefore, a complete health history is required to uncover your constitutional disposition. From here we create a treatment plan designed specifically for you. Print all information and indicate areas that you are unclear about with a question mark.*

Address: \_\_\_\_\_

Phone: Primary \_\_\_\_\_ Secondary \_\_\_\_\_ Email Address \_\_\_\_\_

Emergency Contact & Number: \_\_\_\_\_

Age: \_\_\_\_\_ Gender: M F Marital Status: S M D W

**Describe your primary health concerns:**

1. Condition and duration \_\_\_\_\_  
 Have you been given a diagnosis for this problem? Yes No Diagnosis \_\_\_\_\_  
 Previous treatments and outcomes? \_\_\_\_\_
2. Condition and duration \_\_\_\_\_  
 Have you been given a diagnosis for this problem? Yes No Diagnosis \_\_\_\_\_  
 Previous treatments and outcomes? \_\_\_\_\_
3. Condition and duration \_\_\_\_\_  
 Have you been given a diagnosis for this problem? Yes No Diagnosis \_\_\_\_\_  
 Previous treatments and outcomes? \_\_\_\_\_

**Family Medical History** Check all boxes next to conditions which members of your blood siblings, parents, or grandparents have or had.

- |                                     |   |  |  |   |
|-------------------------------------|---|--|--|---|
| <input type="checkbox"/> Cancer     | <input type="checkbox"/> Diabetes       | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Overweight or Obesity | <input type="checkbox"/> Seizures or Epilepsy |
| <input type="checkbox"/> Asthma     | <input type="checkbox"/> Eczema         | <input type="checkbox"/> Stroke              | <input type="checkbox"/> Heart Disease         | <input type="checkbox"/> Alcoholism           |
| <input type="checkbox"/> Drug Abuse | <input type="checkbox"/> Mental Illness | <input type="checkbox"/> Depression          | <input type="checkbox"/> Kidney Disease        |   |

**Other conditions:** \_\_\_\_\_

**Your Medical History** Check all boxes next to conditions which you currently or previously had.

- |   |  |   |   |  |
|---|--|---|---|--|
| <input type="checkbox"/> Diabetes             | <input type="checkbox"/> Allergies                   | <input type="checkbox"/> Glaucoma         | <input type="checkbox"/> Rheumatic Fever    | <input type="checkbox"/> Heart Disease     |
| <input type="checkbox"/> Stroke               | <input type="checkbox"/> Vein Condition              | <input type="checkbox"/> Thyroid Disorder | <input type="checkbox"/> Asthma             | <input type="checkbox"/> Pneumonia         |
| <input type="checkbox"/> Tuberculosis         | <input type="checkbox"/> Sickle Cell                 | <input type="checkbox"/> Emphysema        | <input type="checkbox"/> Cancer             | <input type="checkbox"/> Sarcoidosis       |
| <input type="checkbox"/> Jaundice             | <input type="checkbox"/> Herpes                      | <input type="checkbox"/> Gonorrhea        | <input type="checkbox"/> Mumps              | <input type="checkbox"/> Measles           |
| <input type="checkbox"/> Chicken Pox          | <input type="checkbox"/> Nervous Disorder or Anxiety | <input type="checkbox"/> Depression       | <input type="checkbox"/> Meningitis         | <input type="checkbox"/> HIV               |
| <input type="checkbox"/> Seizures or Epilepsy | <input type="checkbox"/> Eczema                      | <input type="checkbox"/> Hepatitis        | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Myasthenia Gravis |
| <input type="checkbox"/> Migraines            | <input type="checkbox"/> High Blood Pressure         | <input type="checkbox"/> Snoring          | <input type="checkbox"/> Sleep Apnea        |  |

**Other conditions:** \_\_\_\_\_

**Head • Eye • Ear • Nose • Throat** Check all boxes next to conditions you've had over the past 6 months.

- |   |   |   |  |   |  |
|---|---|---|--|---|--|
| <input type="checkbox"/> Eye strain     | <input type="checkbox"/> Diminished vision        | <input type="checkbox"/> Eye pain       | <input type="checkbox"/> Dry eyes            | <input type="checkbox"/> Itchy eyes       | <input type="checkbox"/> Blurred Vision  |
| <input type="checkbox"/> Red Eyes       | <input type="checkbox"/> Visual disturbances      | <input type="checkbox"/> Cataracts      | <input type="checkbox"/> Gum Problems        | <input type="checkbox"/> Dry mouth        | <input type="checkbox"/> Teeth problems  |
| <input type="checkbox"/> TMJ            | <input type="checkbox"/> Lip, tongue, mouth sores | <input type="checkbox"/> Grinding teeth | <input type="checkbox"/> Excessive Saliva    | <input type="checkbox"/> Enlarged Thyroid | <input type="checkbox"/> Swollen glands  |
| <input type="checkbox"/> Lump in throat |   | <input type="checkbox"/> Sinus problems | <input type="checkbox"/> Hay fever/Allergies | <input type="checkbox"/> Nosebleeds       | <input type="checkbox"/> Ringing in ears |

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- Ring in ears (low) Recurrent Sore Throat Earaches Headaches/Migraines Excessive ear wax (high) Poor hearing Concussions

Other head, eye, ear, nose, throat conditions:

Respiratory

- Cold/flu 3+ times per year Dry cough Cough with phlegm Yellow phlegm White phlegm Clear Phlegm Blood Streaked phlegm Scanty phlegm Copious phlegm Difficult inhalation Difficult exhalation asthma/wheezing Shortness of breath Chest tightness Frequent sneezing

Other respiratory conditions:

Cardiovascular Check all boxes next to conditions you've had over the past 6 months.

- Palpitations High blood pressure Chest pain Rapid heartbeat Slow heartbeat Irregular heartbeat Easy bruising Heart murmurs Varicose veins Low blood pressure Swelling Abnormal bleeding

Other cardiovascular conditions:

Gastrointestinal Check all boxes next to conditions you've had over the past 6 months.

- Bloating Nausea/vomiting Ulcers Mucus in Stool Blood in stools Loose stools Constipation Heartburn Frequent belching Frequent hiccups Stiffness in ribcage Abdominal pain Bad breath Hemorrhoids Black or tarry stools Rectal pain Burning anus Pebble-like stool Dry mouth Excessive saliva

Bowel Movements: Frequency: \_\_\_\_\_ Color: \_\_\_\_\_ Form: \_\_\_\_\_

Other gastrointestinal conditions:

Musculoskeletal Check all boxes next to conditions you've had over the past 6 months.

- Neck Pain Shoulder pain Low back pain Upper back pain Limited range of motion Muscular pain Knee pain Hip pain Other joint pain Muscle spasms/cramps Weak or brittle bones Bone deformity

Other musculoskeletal conditions:

Skin • Nails • Hair Check all boxes next to conditions you've had over the past 6 months.

- Dry Skin Dry Hair Dry Scalp Dandruff Dry lips Eczema Psoriasis Itchy skin Hives Welts Acne Rosacea Boils/Abscesses Dry nails Ridges in nails Hair loss Fungal infections Rashes Herpes Change in skin/hair texture

Premature gray hair

Other skin, nails, or hair conditions:

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Neurologic

- ☐ Tingling ☐ Pins and needles sensation ☐ Paralysis ☐ Loss of balance ☐ Seizures/epilepsy
☐ Tics ☐ Numbness ☐ Stroke

Other neurologic conditions:

Psychological Check all boxes next to conditions you've had over the past 6 months.

- ☐ Anxiety ☐ Anger ☐ Lack of joy/humor ☐ Irritability ☐ Depression
☐ Sadness ☐ Overthinking/Worry ☐ Fear ☐ Mood swings ☐ Short temper
☐ Brain fog ☐ Poor memory

Other psychological conditions:

Urology and Sexual Health Check all boxes next to conditions you've had over the past 6 months.

- ☐ Painful urination ☐ Frequent urination ☐ Dribbling urination ☐ Urinary incontinence ☐ Bedwetting
☐ Unable to hold urine ☐ Kidney stones ☐ Decreased libido ☐ Wake to urinate ☐ Increased libido
☐ Urinary tract infection

Other genitourinary conditions:

Male Reproductive Health Check all boxes next to conditions you've had over the past 6 months.

- ☐ Premature ejaculation ☐ Nocturnal emissions ☐ Impotence ☐ Premature ejaculation ☐ Testicular pain
☐ Testicular swelling ☐ Penile discharge ☐ Pain with ejaculation ☐ Prostate condition

Other male reproductive conditions:

Gynecology Check all boxes next to conditions you've had over the past 6 months and provide requested information for appropriate questions.

Are you currently pregnant? ☐ Yes ☐ No If yes, how many weeks? \_\_\_\_\_

- ☐ Irregular periods ☐ Pre-menstrual tension ☐ Vaginal discharge ☐ Bleeding between cycles ☐ Clotting
☐ Infertility ☐ Painful periods ☐ Vaginal sores ☐ Vaginal odor ☐ Menopausal symptoms
Length of period: \_\_\_\_\_ Birth control type: \_\_\_\_\_ #Pregnancies: \_\_\_\_\_ #Live births: \_\_\_\_\_ #Miscarriages: \_\_\_\_\_
#Abortions: \_\_\_\_\_ Age at 1st period: \_\_\_\_\_ #Still births: \_\_\_\_\_ #Days in cycle (day1 to day1): \_\_\_\_\_ 1st day of last period: \_\_\_\_\_

Other gynecological conditions:

Lifestyle

How many meals per day do you eat? \_\_\_\_\_
List what you had for breakfast yesterday: \_\_\_\_\_
List what you had for lunch yesterday: \_\_\_\_\_
List what you had for dinner yesterday: \_\_\_\_\_
List what snacks you had yesterday: \_\_\_\_\_
List what beverages you had yesterday: \_\_\_\_\_
List how much water you had yesterday: \_\_\_\_\_
Do you follow a particular type of nutrition plan or restrict certain things from your diet? Explain \_\_\_\_\_
Do you exercise 3 or more times per week? ☐ Yes ☐ No What is your exercise routine? \_\_\_\_\_

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Spiritual practice: \_\_\_\_\_

Do you consume any of the following?

| Substance                     | How often? | How much? |
|-------------------------------|------------|-----------|
| Caffeine                      |            |           |
| Marijuana                     |            |           |
| High Fructose Cornsyrup (HFC) |            |           |
| Alcohol                       |            |           |
| Soda                          |            |           |
| Television and Movies         |            |           |
| Dairy                         |            |           |
| Drugs <i>What type?</i>       |            |           |

Lotus on the Nile



WELLNESS CENTER