

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: _____

Date of Birth: ____/____/____ 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"/> Recurrent Sore Throat | <input type="checkbox"/> Sinus problems | <input type="checkbox"/> Hay fever/Allergies | <input type="checkbox"/> Nosebleeds | <input type="checkbox"/> Ringing in ears (high) |
| <input type="checkbox"/> Ringing in ears (low) | <input type="checkbox"/> Poor hearing | <input type="checkbox"/> Earaches | <input type="checkbox"/> Headaches/Migraines | <input type="checkbox"/> Excessive ear wax | <input type="checkbox"/> Concussions |

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

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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 ☐ Warts
☐ Acne ☐ Rosacea ☐ Boils/abscesses ☐ Dry nails ☐ Ingrown nails
☐ Hair loss ☐ Fungal infections ☐ Rashes ☐ Herpes ☐ Change in skin/hair texture
☐ Premature gray hair

Other skin, nails, or hair conditions:

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 ☐ Fear ☐ Mood swings ☐ Short temper
☐ Brain fog ☐ Poor memory

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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 regularly? Yes No What is your exercise routine? _____
 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>		