East West Academy of Healing Arts

PERSONAL HISTORY & EXAMINATION FORM

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Date of Birth:______________________________________ Date: ___________________________

Name: _________________________Age:_____Sex:__________ Marital Status: (S) (M) (D) (W)

Address: ________________________ City:_________________ State:____ Zip Code: ______

Telephone (Home): (_____)_____________ Telephone (Business) (_____)_____________

Social Security No: ___________________

Fax: (_____)_____________ E-mail Address: ____

Occupation: ______________________ Employer: ________________ Years Employed:______

Address: ________________________ City ______________ State ______ Zip Code ________

Spouse's Name __________________ Occupation ____________ Employer _______________

Number of Children & Ages: ____

Person Responsible For This Account: __________________ Referred By:_________________

Insurance Company: ____ Plan No: _____________

Physician: _____________________________________ Telephone (______)_________________

Address:____

Present Complaint (Date Incurred) _______________ Onset: (Sudden) _____ (Gradual) _____

Diagnosis ____

Briefly Describe Your Condition ____

____

Have You Had A Similar Condition Before? ________ If Yes, Please Explain ________________

____ Relieved by ______________________________

Previous Diagnosis & Treatment __________________________________ Previous Rx ________

Past History & Treatment:

Accidents ______________________________________ Surgery _________________________

Hospital Treatment ____

Chiropractic or Acupuncture ____

Other (Please Specify) ____

Symptoms / Diseases:

Pain In: Low Back _______ Upper Back _______ Neck _______ Hip _______ Legs ________

Shoulder ________ Knees ________ Feet _______ Elbow ______ Other __________

Heart Disease ____ Stomach Disease ____ Lung Disease _______ Kidney Disease ____

Liver Disease _____ Blood Pressure ____ Hypertension _______ Gonorrhea _______

Syphilis ______ Herpes ______ Herpes _______ ARC _______ AIDS _______ HIV+ _______

Other (Please Specify) ____

(CONTINUED ON THE OTHER SIDE)

FAMILY HISTORY. STATE HEALTH OF:

Father ____________ Mother ____________ Brother(s) _____________ Sister(s) ______________

Have any of the following conditions occurred in your family?

High Blood Pressure ______ Heart Disease ________ Arthritis: ___________________

Strokes ________________ Stomach Disease ______ Rheumatoid _______________

Diabetes _______________ Lung Disease _________ Gout ______________________

Cancer _________________ Kidney Disease ________ Thyroid ___________________

Insanity _________________ Liver Disease _________ Other _____________________

PRESENT HABITS:

Do you drink: Coffee _________ (Cups/Day) Alcohol ____________ Tea ___________

Habitual use of: Tobacco ___________ Sugar ____________ Salt _______________

Meals/Day _______________ Exercise (Hrs.) ____________ Type of Exercise _________

____

PRESENT CONDITION:

Fever/Chills __________________________

Excess Perspiration:

Working _________________________

Resting _________________________

Night ___________________________

Preference For: Hot Foods _____________

Cold Foods ________________

Hot Liquids ________________

Cold Liquids _______________

When Thirsty, Do You:

Want to Drink ______________

Not want to Drink ___________

Hours Sleep/Night ______ Restful ______

Fall asleep easily ___________

Dream Much _______________

Awaken at Night ____________

Return to sleep easily ________

Energy Level: Norm ___ Hi ____ Low ___

Tired in Morning ________

Tired in Afternoon _______

Bowel Movements Are:

Norm ___ Constipated ___

Loose __ Dry ___ Hard ___

Other __________________

Urination: _______________

Frequency: _________/Day

Amount:

Normal _____ High ______

Low _______

Color: Clear ______ Straw _____

Yellow _____ Dark ______

Height _______________________________

Weight _______________________________

FOR WOMEN ONLY:

# of Pregnancies ________ Children ________ Miscarriages ________ D & C ________

Menstrual Period: Age at onset ______ Periodicity _____/Days Length ________/Days

Flow: Scanty ______ Heavy ______ Cramping: Before Menses ______ After _______

Unusual Discharge? ____