NEW MOON HEALING ARTS
COURTNEY LOMONTE L.AC
ACUPUNCTURE, SHIATSU MASSAGE & REIKI

Client Health History

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

Date of Birth: _____/_____/_____ Age: _____ Marital status: S M D W Living w/ partner

Address: _____ City: _____ State:_____

Zip:_____ Phone #: _____ (Cell/Home) Email: _____

Successful health care and preventative medicine are only possible when the practitioner has a complete understanding of the patient physically, mentally and emotionally. Please complete this questionnaire as thoroughly as possible. Print all information. Thank you. If you need more room, please use the backside of the page.

1. **What are your most pressing health concerns in order of importance to you? What is the chief concern you would like to address today?**

Condition	**Past Treatment**
a. _____	_____
How does this condition affect you? _____	
b. _____	_____
How does this condition affect you? _____	
c. _____	_____
How does this condition affect you? _____	

2. If applicable, please list anything you are hypersensitive or allergic to or special diets you are on:

_____

3. Please list any medications, supplements or herbs you are currently taking:_____

_____

4. Do you have any reason to believe you may be pregnant? Y N If yes, how many weeks _____

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

6. **Hospitalizations / Surgeries / Broken bones / Injuries & when they occurred.**

_____

_____

_____

Please CIRCLE any symptoms that you experienced in the last three months.

7. **Mental / Emotional:**

Mood Swings Nervousness Mental Tension/ Stress Anxiety Depression

PTSD Recent Trauma Grief Anger Mental Illness

8. **Energy and Immunity:**

Fatigue Wired/Ungrounded feeling Chronic Infections Auto Immune Disorder

9. **Head, Eye, Ear, Nose, and Throat:**

Impaired Vision Eye Pain/Strain Glaucoma Glasses/Contacts Tearing/Dryness

Impaired Hearing Ear Ringing Earaches Headaches Sinus Problems

Nose Bleeds Frequent Sore Throats Dental Issues TMJ/Jaw Problems Allergies

10. **Respiratory**:

Pneumonia Frequent Common Colds Difficulty Breathing Emphysema

Persistent Cough Asthma Tuberculosis Shortness of Breath

11. **Cardiovascular**:

Heart Disease Chest Pain Swelling of Ankles High Blood Pressure

Palpitations/Fluttering Stroke Heart Murmurs Rheumatic Fever Varicose Veins

12. **Gastrointestinal**:

Ulcers Changes in Appetite Nausea/Vomiting Bloating Heartburn/ Acid reflux

Gas Gall Bladder Disease Liver Disease Hepatitis Hemorrhoids Abdominal Pain

13. **Genito-Urinary Tract**:

Kidney Disease Painful Urination Frequent UTI Frequent Urination Heavy Flow

Kidney Stones Impaired Urination Blood in Urine Frequent Urination at Night

14. **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

15. **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: _____

16. **Musculoskeletal (Left / Right / Both)**

Neck/Shoulder Pain Muscle Spasms/Cramps Arm Pain Upper Back Pain Mid Back Pain

Low Back /Hip Pain Leg Pain Joint Pain (if so, where?)_____

17. **Neurologic**:

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

18. **Endocrine**:

Hypothyroid Hyperthyroid Hypoglycemia Diabetes Night Sweats Feeling Hot or Cold

19. **Other**:

Cancer Anemia Eczema/ Skin Issues Cold Hands/Feet Insomnia/Sleeping troubles

20. **Is there anything else I should know?** _____

21. **Lifestyle:**

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

b. Exercise : _____

c. Spiritual practice: _____

d. Do you feel supported by your friends and family? Y N

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

f. Occupation: _____ Hours/Week: _____

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

g. Nicotine/Alcohol/Caffeine/Cannabis Use: _____

h. How many glasses of non-caffeinated, non-carbonated beverages do you drink per day? _____

i. Interests and hobbies: _____

22. Have you ever received acupuncture / shiatsu / reiki ? Y N Which & When _____

23. How did you hear about me?_____

Patient Signature X_____ Date _____