Sheridan Richardson, L.Ac
827 Bayside Rd.
Arcata, Ca 95521
(707) 822-4300

PATIENT INFORMATION

Patient's Name:_____ **Date** _____

Address: _____ **Zip Code:** _____

Home Phone: _____ **Work Phone**: _____

Date of Birth: _____ Gender: _____ Occupation: _____

Emergency Contact_____ Relationship _____

Emergency Contact Phone/Address _____

Please Complete Questionnaire As Completely as Possible:

1. Are you currently receiving health care? Y / N If yes, from whom? _____

_____

If no, when did you last receive health care? _____

2. If no, when and where did you last receive health care? _____

_____

3. **Please identify the chief reasons for your visit below**:

I. _____ Onset: _____

How does this condition affect you? _____

Past treatment: _____

II. _____ Onset: _____

How does this condition affect you? _____

Past treatment: _____

III. _____ Onset: _____

How does this condition affect you? _____

Past treatment: _____

4. Do you have any reason to believe you are pregnant? _____

5. Are you currently suffering from any chronic illness? _____

6. Please list any prescription medications, over-the-counter medications, vitamins, and supplements you are taking:

_____

_____

7. If applicable, please list any foods, drugs, or medications you are hypersensitive or allergic to and please include the type of reaction:

_____

_____

8. **Height**: _____ **Weight**: _____ Past Maximum Weight: _____ When? _____

9. **Blood Pressure**: What is your most recent Blood pressure reading? _____/_____ Date: _____

10. **Hospitalizations and Surgeries**:

Reason: _____ When? _____

Reason: _____ When? _____

Reason: _____ When? _____

_____

11. **Immunizations** (please circle any that apply):

Scarlet fever Polio Tetanus Measles/Mumps/Rubella Pertussis

Diptheria Other: _____

12. **Childhood Illness** (please circle any that apply):

Scarlet fever Diphtheria Rheumatic Fever Mumps Measles German Measles

Chicken Pox

13. **Family History**:	Mother	Father	Brothers	Sisters	Spouse	Children
Age:	_____	_____	_____	_____	_____	_____
Health (G:good,P:poor)	_____	_____	_____	_____	_____	_____
Age at Death (if deceased):	_____	_____	_____	_____	_____	_____
Cause of Death:	_____	_____	_____	_____	_____	_____

Check any conditions that family members have had:

	Mother	Father	Brothers	Sisters	Spouse	Children
Cancer:	_____	_____	_____	_____	_____	_____
Diabetes:	_____	_____	_____	_____	_____	_____
Heart Disease:	_____	_____	_____	_____	_____	_____
High Blood Pressure:	_____	_____	_____	_____	_____	_____
Stroke:	_____	_____	_____	_____	_____	_____
Mental Illness:	_____	_____	_____	_____	_____	_____

14. **Emotional** (please circle any that you experience and underline any that you have had in the past):
Mood Swings Nervousness Mental Tension

15. **Energy and Immunity** (please circle any that you experience and underline any that you have had in the past):

Fatigue Slow Wound Healing Chronic Infections Chronic Fatigue Syndrome

16. **Head, Eye, Ear, Nose and Throat** (please circle any that you experience and underline any that you have had in the past):

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

Impaired Hearing Ear Ringing Earaches Headaches Sinus Problems

Nose Bleeds Frequent Sore Throats Teeth Grinding TMJ/Jaw Problems Hay Fever

17. **Respiratory** (please circle any that you experience and underline any that you have had in the past):
Pneumonia Frequent Common Colds Difficulty Breathing Emphysema Pleurisy

Persistent Cough Asthma Tuberculosis Shortness of Breath Other: _____

18. **Cardiovascular** (please circle any that you experience and underline any that you have had in the past):
Heart Disease Chest Pain Swelling of Ankles High Blood Pressure Palpitations/Fluttering

Stroke Heart Murmurs Rheumatic fever Varicose Veins

19. **Gastrointestinal** (please circle any that you experience and underline any that you have had in the past):
Ulcers Changes in Appetite Nausea/Vomiting Epigastric Pain Passing Gas Heartburn

Belching Gall Bladder Disease Liver Disease Hepatitis B or C Hemorrhoids Abdominal Pain

Stool: Diarrhea Constipation Undigested Food Mucous Blood in Stool

20. **Genito-Urinary Tract**: (please circle any that you experience and underline any that you have had in the past):
Kidney Disease Painful Urination Frequent Urinary Tract Infections Frequent Urination

Venereal Disease Kidney Stones Impaired Urination Frequent Urination at Night

Blood in Urine

21. **Female Reproductive/Breasts** (please circle any that you experience and underline any that you have had in the past):
Irregular Cycles Breast Lumps/Tenderness Nipple Discharge Heavy Flow Clotting

Bleeding Between Cycles Vaginal Discharge Premenstrual Symptoms Menopausal Issues

Difficulty Conceiving Infertility

22. **Menstrual/Birthing History**:

Age of First Menses: _____ # of Days of Menses: _____ Length of Cycle: _____

Birth Control: _____ # of Pregnancies: _____ # of Miscarriages _____

# of Abortions: _____ # of Live Births: _____

23. **Male Reproductive** (please circle any that you experience and underline any that you have had in the past):
Sexual Difficulties Prostate Issues Testicular Pain/Swelling Penile Discharge

24. **Musculoskeletal** (please circle any that you experience and underline any that you have had in the past):
Neck/Shoulder Muscle Spasms/Cramps Arm Pain Upper Back Pain Mid Back Pain

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

25. **Neurologic** (please circle any that you experience and underline any that you have had in the past):

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

26. **Endocrine** (please circle any that you experience and underline any that you have had in the past):
Hypothyroid Hypoglycemia Hyperthyroid Diabetes Mellitus Night Sweats

Cold Sweats Feeling Hot or Cold

27. **Other** (please circle any that you experience and underline any that you have had in the past):

Anemia Cancer Rashes Eczema/Hives Cold Hands/Feet

Do you have any chronic infections? _____

Is there anything else you would like me to know? _____

28. **Lifestyle**

Please indicate typical food intake:

Breakfast _____
Lunch _____
Dinner _____
Snacks _____

Daily Exercise: _____

Sleep Habits: _____

Education: _____

Occupation: _____ Hours/Week: _____

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

Nicotine/Alcohol/Caffeine use: _____

Have you experienced any major traumas? Y N Please explain: _____

_____

Consumption of liquids: _____

Television habits: _____

Interests and Hobbies: _____