

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

Diphtheria      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:

	<u>Mother</u>	<u>Father</u>	<u>Brothers</u>	<u>Sisters</u>	<u>Spouse</u>	<u>Children</u>
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: \_\_\_\_\_