Healing Points Wellness Center
Gerald Joseph Djuth, L.Ac.
2701 I Street, Sacramento, CA 95816
Phone 916-760-7381 Fax 916-442-2008

Personal History

Name_____Birthdate_____Male ❑ Female ❑
Address Street_____ SSI# _____-_____-_____
City_____State_____Zip_____Home Phone_____-_____
Email_____ Cell Phone _____-_____
✔ One ❑Married ❑Single ❑Widowed ❑Divorced ❑Separated Work Phone _____-_____
Employer_____ Spouse's Name_____
_____ Spouse's SSI# _____-_____-_____
Position held_____ Spouse's Employer _____
Referred by _____ Business Phone _____-_____
❑Physician _____ Names & ages of Children_____
❑Friend _____ _____
Emergency Contact_____#_____-_____ Relationship_____
Who is responsible for your bill? ❑You ❑Spouse ❑Workers'Comp. ❑Auto Insurance ❑Medicare ❑Medicaid
❑Personal Health Insurance (Name)_____Health card #_____
Insured Person's Name_____ Date of Birth_____

Current Health Condition

Improvement Desired:_____
Other Doctors Seen for this Condition: ❑Yes ❑No Name:_____
Type of treatment:_____Results:_____
When did this condition begin?_____Has this condition occurred before? ❑Yes ❑No
Is Condition: ❑Job Related ❑Auto Accident ❑Home Injury ❑Fall ❑Other _____
Date of Accident:_____ Time of Accident:_____
Have you made a report of your accident to your employer: ❑Yes ❑No
Drugs you take now: ❑Nerve Pills ❑Pain Killers/Muscle Relaxers ❑Blood Pressure Medicine ❑Insulin
❑Other_____
Do you wear a shoe lift? ❑Yes ❑No❑
Do you suffer from any condition other than that which you are now consulting us?_____

Past Health History

Please ✔ and describe:
Major Surgery/Operations: ❑Appendectomy ❑Tonsillectomy ❑Gall Bladder ❑Hernia ❑Back Surgery
❑Broken Bones ❑Other: _____
Major Accident or Falls: _____
_____
Hospitalization (Other than above): _____
_____
Previous Acupuncture Care: ❑None ❑Doctor's Name & approximate date of last visit: _____
_____

Below are a list of diseases which m seem unrelated to the purpose of your ap ntment. However, these questions must be answered carefully as these problems can affect your overall course of care.

CHECK ANY OF THE FOLLOWING DISEASES YOU HAVE HAD:

- ☐ Pneumonia
- ☐ Rheumatic Fever
- ☐ Polio
- ☐ Tuberculosis
- ☐ Whooping Cough
- ☐ Anemia
- ☐ Measles
- ☐ Mumps
- ☐ Small Pox
- ☐ Chicken Pox
- ☐ Diabetes
- ☐ Cancer
- ☐ Heart Disease
- ☐ Thyroid
- ☐ Influenza
- ☐ Pleurisy
- ☐ Arthritis
- ☐ Epilepsy
- ☐ Mental Disorders
- ☐ Lumbago
- ☐ Eczema

INTAKE

- ☐ Coffee
- ☐ Tea
- ☐ Alcohol
- ☐ Cigarettes
- ☐ White Sugar

Have you been tested HIV positive? ☐ Yes ☐ No

CHECK ANY OF THE FOLLOWING YOU HAVE HAD THE PAST 6 MONTHS:

MUSCULO-SKELETAL CODE

- ☐ Low Back Pain
- ☐ Pain Between Shoulders
- ☐ Neck Pain
- ☐ Arm Pain
- ☐ Joint Pain/Stiffness
- ☐ Walking Problems
- ☐ Difficult Chewing/Clicking Jaw
- ☐ General Stiffness

NERVOUS SYSTEM CODE

- ☐ Nervous
- ☐ Numbness
- ☐ Paralysis
- ☐ Dizziness
- ☐ Forgetfulness
- ☐ Confusion/Depression
- ☐ Fainting
- ☐ Convulsions
- ☐ Cold/Tingling Extremities
- ☐ Stress

GENERAL CODE

- ☐ Fatigue
- ☐ Allergies
- ☐ Loss of Sleep
- ☐ Fever
- ☐ Headaches

GASTRO-INTESTINAL CODE

- ☐ Poor/Excessive Appetite
- ☐ Excessive Thirst
- ☐ Frequent Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Hemorrhoids
- ☐ Liver Problems
- ☐ Gall Bladder Problems
- ☐ Weight Trouble
- ☐ Abdominal Cramps
- ☐ Gas/Bloating After Meals
- ☐ Heartburn
- ☐ Black/Bloody Stool
- ☐ Colitis

GENITO-URINARY CODE

- ☐ Bladder Trouble
- ☐ Painful/Excessive Urination
- ☐ Discolored Urine

C-V-R CODE

- ☐ Chest Pain
- ☐ Short Breath
- ☐ Blood Pressure Problems
- ☐ Irregular Heartbeat
- ☐ Heart Problems
- ☐ Lung Problems/Congestion
- ☐ Varicose Veins
- ☐ Ankle Swelling
- ☐ Stroke

EENT CODE

- ☐ Vision Problems
- ☐ Dental Problems
- ☐ Sore Throat
- ☐ Ear Aches
- ☐ Hearing Difficulty
- ☐ Stuffed Nose

MALE/FEMALE CODE

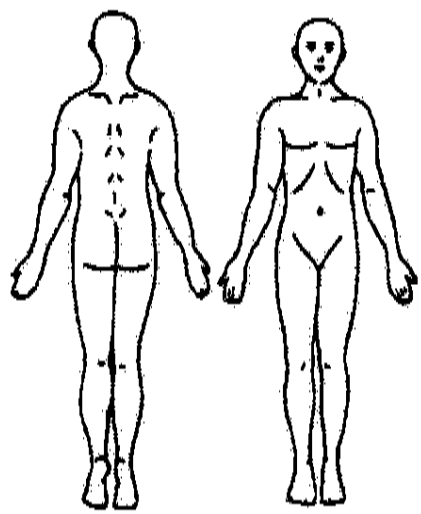
- ☐ Menstrual Irregularity
- ☐ Menstrual Cramps
- ☐ Vaginal Pain/Infection
- ☐ Breast Pain/Lumps
- ☐ Prostate/Sexual Dysfunction
- ☐ Other Problems
- ☐ _____
- ☐ _____
- ☐ _____

FEMALES ONLY:

When was your last period?_____

Are you pregnant?

☐ Yes ☐ No ☐ Not Sure



Please outline on the diagram the area of your discomfort

FAMILY HISTORY

The following members have a same or similar problem as I do:

- ☐ Mother
- ☐ Father
- ☐ Brother
- ☐ Sister
- ☐ Spouse
- ☐ Child

DO NOT WRITE BELOW THIS LINE

ANALYSIS:

DIAGNOSIS:

Patient Accepted: ☐ Yes ☐ No ☐ Referred

Doctor's Signature