Naomi Takata Acupuncture and Shiatsu Therapy
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HEALTH HISTORY QUESTIONNAIRE

Please complete the following as thoroughly as possible. If you have any questions, please ask. Information provided will remain confidential.

Date___________ Name____

Address____

City ____State/Zip________________________

Referred by____

Email ____

Age__________ DOB_____________ Home phone_______________________________________

O Male O Female Cell phone _______________________________________

Height __________Weight _________ Work phone _______________________________________

Primary Care Physician___________________________________ Phone_____________________

Emergency Contact Name__________________________________ Relation to you _____________

Emergency Contact person's Phone # ____

Occupation____

Have you been treated by acupuncture or Oriental Medicine before? O Yes O No

Main problem you would like help with

____
____
____

How long ago did this problem begin? Be specific

____
____

Have you been diagnosed for this problem? If so what is the diagnosis and by whom?

____
____

Secondary problem you would like help with

____
____

Additional problems
____
____

What kinds of treatments have you tried?

0 Western Medicine 0 Acupuncture 0 Herbal Medicine
0 Massage 0 Physical Therapy 0 Chiropractic
0 Homeopathy 0 Other ______________________________

How confident are you that you can resolve the symptoms of your main complaint with acupuncture?

0 very confident 0 confident 0 moderately confident
0 slightly confident 0 not confident

Past medical history of significant illness (please circle)

Asthma allergies diabetes cancer stroke heart disease

High blood pressure seizures hepatitis rheumatic fever thyroid disease

other ____

Hospitalizations/Surgeries (include dates)
____
____
____
____

Significant Trauma (auto accidents, falls, etc.)
____
____
____

Allergies (drugs, food, chemicals, metals)
____
____
____

Family medical History (please circle)

Asthma allergies diabetes cancer stroke heart disease

High blood pressure seizures thyroid hepatitis rheumatic fever

Thyroid disease other ____

Medications taken within the last two months (vitamins, prescription/non-prescription drugs, herbs)

Stressful areas your life____

Do you have a regular exercise program? Yes No If yes, please explain

Do you follow any type of special diet? Yes No If yes, please explain

Describe your average daily diet
Morning____
Afternoon____
Evening____
Snacks____

Do you smoke? Yes No
How many cups of caffeinated beverages do you drink per day?____________________________
How much water do you drink daily?____
How much alcoholic beverages do you drink weekly?_______________________________________
Describe any use of drugs for non-medical purposes______________________________________

Please circle any of the following that apply, particularly in the last three months

GENERAL
Fevers chills fatigue sweat easily poor sleeping Night Sweats
weight loss weight gain change in appetite cravings bleed or bruise easily
Strong thirst for 0 hot drinks 0 cold drinks sudden energy drops/ when?________________
Peculiar tastes or smells

SKIN AND HAIR
Rashes ulcerations hives itching eczema pimples
Dandruff loss of hair recent moles psoriasis dermatitis acne
Change in hair or skin texture any other hair/skin problems?______________________________

HEAD, EYES, EARS, NOSE, THROAT
Dizziness concussions migraines glasses eye strain eye pain
Poor vision night blindness color blindness cataracts blurry vision
Earaches ringing in ears spots in front of eyes poor hearing sinus problems
Nose bleeds recurrent sore throats grinding teeth clenching jaw facial pain
Sores on lips or tongue teeth problems jaw clicks
Headaches where and when?____
Any other head or neck problems?____

CARDIOVASCULAR
High blood pressure low blood pressure chest pain fainting irregular heart beat
Difficulty breathing blood clots phlebitis cold hands or feet swelling of hands
Swelling of feet varicose or spider veins palpitations palpitations at rest

RESPIRATORY
Cough coughing blood asthma bronchitis pneumonia
Pain with deep breath chest tightness difficulty breathing when lying down

Phlegm production, what color?____

GASTROINTESTINAL
Nausea vomiting diarrhea constipation gas
Belching black stools blood in stools indigestion bad breath
Rectal pain hemorrhoids bleeding gums food stagnation bloating/edema
Acid reflex/GERD hernia excessive appetite poor appetite IBS/Crohn's
Colitis slow digestion abdominal pain/cramps chronic laxative use
Loose stools, more than 2 per day
Any other problems with stomach or intestines?_________________________________

GENITO-URINARY
Frequent urination blood in urine pain upon urination urgency to urinate
Unable to hold urine kidney stones decrease in flow impotency
Sores on genitals any particular color to your urine?___________________________
Do you wake up at night to urinate? Yes No If yes, how many times?_________________
Any other problems with your genital or urinary systems?__________________________

REPRODUCTIVE AND GYNECOLOGIC
Are you pregnant? Yes NO
Is there a possibility that you may be pregnant? Yes NO
Number of pregnancies______ Live Births ____ Abortions_______ Miscarriages____________
Premature births__________________ Last menses (if applicable)___________
Age at first menses________________ Last PAP__________________________
Duration of menses________________
Time between menses____________ Unusual character of blood (heavy, scanty)_____________
Do you practice birth control? Yes No If yes, what type and for how long?_________________
Irregular periods painful periods clots breast lumps
Breast tenderness vaginal sores vaginal discharge vaginal dryness
Endometriosis uterine fibroids polycystic ovarian disease fibrocystic breast tissue

MUSCULOSKELETAL
Neck pain rotator cuff knee pain foot/ankle pain muscle pain
Muscle spasm muscle weakness shoulder pain hip pain sciatica
Bursitis hand/wrist pain carpal tunnel sprains/strains tendonitis
Back pain low back_____________ middle back ________________ upper back_____________
Soreness/weakness of lower body (back, hip, knee, ankle, foot)

NEUROLOGICAL AND PSYCHOLOGICAL
Seizures dizziness loss of balance areas of numbness poor memory
Concussion poor coordination bad temper anxiety depression
Easily susceptible to stress nervousness ADD/ADHD manic depression
Have you ever been treated for emotional problems? Yes No
Have you ever considered or attempted suicide? Yes No Any other neurological or psychological problems? ____
____

COMMENTS (any other problems you would like to discuss)______________________________
____