Better Life Acupuncture

Health History Questionnaire

Name	Date of Birth	
Address	Primary Phone	
	Email address	
Height _____ Weight _____	(Circle) Occupation/Retired/Disabled/Unemployed	
Have you ever been treated by acupuncture before?	How did you hear about our clinic?	
Emergency Contact (and Relationship)		Phone

Insurance Company		Provider Phone #	
Policy Holder ID #	Policy Holder Name		Policy Holder DOB
Number of visits allowed	Co-Pay amount $	Co-Insurance %	Deductible amount $

Main Health Issues

Please write your health issues/concerns in order of importance to you. Mark on the scale from 1-10 the severity of the condition (1 = slight and 10 = can't imagine it being worse.)

Primary Health Concern: _____

Please rate the severity of the condition and impact on the quality of your life? _____ / 10

When did it start? _____

Have you been given a diagnosis for the problem? _____
If so, when? _____ Any treatments given? _____

Does heat make it better, worse or have no change? _____

Does cold make it better, worse or have no change? _____

Does damp weather make it better, worse or no change? _____

What has helped you with the issue? _____

What makes the issue worse? _____

What are your health goals? _____

Secondary Health Concern: _____

Please rate the severity of the condition and impact on the quality of your life? _____ / 10

When did it start? _____

Have you been given a diagnosis for the problem? _____
If so, when? _____ Any treatments given? _____

Does heat make it better, worse or have no change? _____

Does cold make it better, worse or have no change? _____

Does damp weather make it better, worse or no change? _____

What has helped you with the issue? _____

What makes the issue worse? _____

What are your health goals? _____

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Health History Circle the "you" if you have/ had the condition and note the year it started. Circle the "family" if there is a family history of the condition.				
Heart Disease You/family Year:	Cancer: you/family Year: Type:	Diabetes: you/family Year: Type:	High/Low blood pressure: you/family Year:	Asthma: you/family Year:
Auto Immune d/o: you/family Year:	HIV/Aids: you/family Year:	Hepatitis: you/family Year: Type:	Seizure d/o: you/family Year:	Allergies: you/family Year:
Stroke: you/family Year:	Pacemaker: you/family Year:	Kidney disease: you/family Year:	Thyroid disease: you/family Year:	Mental illness you/family Year:
Osteoporosis: you/family Year:	Anemia: you/family Year: Type:	Herpes: you/family Year: Type:	Lyme disease: you/family Year:	Alcoholism: you/family Year:

Habits Amount/week If quit – what year	Coffee	Tea	Soda	Tobacco	Alcohol	Drugs
Diet Do you have a specific diet now or in the past? Describe w/dates						
Injuries/Surgeries Please note what body area and when it occurred.						
Exercise Do you exercise regularly? Yes/No, If so, what & how often						

Medications Please note all medications, herbs and supplements that you are taking along with approximate dosage.	
Medications	**Supplements/Herbs**

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Symptoms

Circle any symptoms you have had in the past month

Temperature
Cold hands or feet
Chills
Cold "in the bones"
Areas of numbness
Hot hands, feet, chest
Hot flashes
Hot in the afternoon
Hot in the night
Thirst for cold/hot drinks
Thirst, no desire to drink
Absence of thirst
Excessive thirst
Night sweats
Unusual sweats

Skin
Dry skin
Dry hair
Dry brittle nails
Dry mouth
Dry lips
Dry throat
Dry nose/nosebleeds
Edema/swelling
If so, where _____
Rashes –where _____
Itching- where _____
Oily skin
Oily hair
Acne
Bruise Easily

Head, Eyes, Ears, Throat
Headaches/Migraines
Concussion
Sinus congestion
Post nasal drip
Sore throat
Dry, red, itchy eyes
Poor vision
Night blindness
Spots in front of eyes
Poor hearing
Ringing in ears
Excessive earwax
Grinding/clenching
Dental problems
Mouth sores

Chest & Respiratory
Cough
Coughing blood
Difficulty breathing/SOB
Phlegm? Color?
Pain w/deep breath
Pneumonia
Wheezing/Asthma
Bronchitis
Frequent colds/flu
Irregular heartbeat
Chest pain/pressure
Palpitations
Blood clots
Fainting
Other? _____

Digestion
Stools keep shape? Y / N
BM: How often?
___times, every ____days
Alternating diarrhea & Constipation (IBS)
Dry stools/hard to pass
Hemorrhoids
Indigestion
Gas
Bloating
Belching
Poor appetite
Nausea/vomiting
Bad breath
Heartburn
Excessive hunger

Genital-Urinary
Pain or irritation
Urgency to urinate
Incontinence/leakage
Decrease in flow
Night urination
Fluid in = Fluid out Y / N
Color of urine? _____
Cloudy urine
Blood in urine
Kidney stones
Any Infections

Sleep
Hours/night _____
Difficulty falling asleep
Wake at night
Disturbing dreams
Restless sleep
Not rested upon waking

Neuropsychological
Seizures
Areas of numbness
Poor memory
Confusion
Easily susceptible to stress
Loss of balance
Loss of coordination
Other? _____

Energy
Sudden energy drop
Time of day _____
Energy drop after eating
Fatigue
Dependence on caffeine
Wired/ungrounded
Body/limbs feel heavy
Body/limbs feel weak
Hard to concentrate
Dizziness/lightheaded
Change in sex drive
Weight gain/loss

Musculoskeletal
Jaw pain
Neck pain
Back pain
Shoulder/arm pain
Hand/wrist pain
Hip pain
Knee/Leg/Ankle pain
Foot pain
Joint pain
Limited range of motion
Other? _____

Emotions
Anger/Irritability
Anxiety
Worry
Obsessive thinking
Sadness
Grief
Depression
Joy
Fear
Timid/ Shy
Indecision

Men's Health
Genital pain
Sores, discharge
Jock itch
Nocturnal emission
Premature ejaculation
Erectile dysfunction
Prostate disease
Benign prostrate hyperplasia (BPH)

Women's Health
Age of 1st menses: _____
Last menstrual date: _____
Irregular menses
Painful periods
Fibroids/cysts
Yeast infections
PMS – mild or severe
Breast lump/pain/cysts
IUD/birth control pill
IVF treatment
# of pregnancies: _____
# of miscarriages: _____

In the diagram below, please indicate where you are currently experiencing pain.

A = ACHE B = BURNING N = NUMBNESS

P = PINS & NEEDLES S = STABBING O = OTHER