Confidential Health History Questionnaire

Name:	**Phone:**	Home:	Work:
Street:	**Age:**	**Height:**	**Weight:**
City:	**Occupation:**		
State: **Zip:**	**Marital Status:**		
Date of Birth:	**Place of Birth:**		
Family Physician:			
In Emergency Notify:			
Referred by:			
Number of Children & Ages:			
Have you ever been treated by acupuncture or Oriental medicine before? Y N			

Main Problem(s): _____

When did this begin?: _____

To what extent does this problem interfere with your daily activities

_____

Have you been given a diagnosis for this problem? If so, what?

_____

What kinds of treatment have you tried?

_____

Significant Illnesses: (circle those that apply) Cancer Diabetes Hepatitis Stroke Seizures High Blood Pressure Heart Disease Rheumatic Fever Thyroid Disease Venereal Disease Other _____

Surgeries:

_____

Significant Trauma (physical, emotional):

_____

Birth History: (prolonged labor, forceps delivery, etc.):

_____

Allergies: (drugs, chemicals, foods):

_____

Family Medical History: Cancer Diabetes High Blood Pressure Stroke Allergies Heart Disease Thyroid Disease Seizures Asthma Other:

_____

Medications: _____

_____

Do you have a regular exercise program? _____ **Please describe:**

_____

_____

Have you ever been on a restricted diet? ____ **What kind?**

_____

Please describe your average daily diet:

Morning **Afternoon** **Evening**

_____

_____

_____

Lifestyle: (please check those that apply)

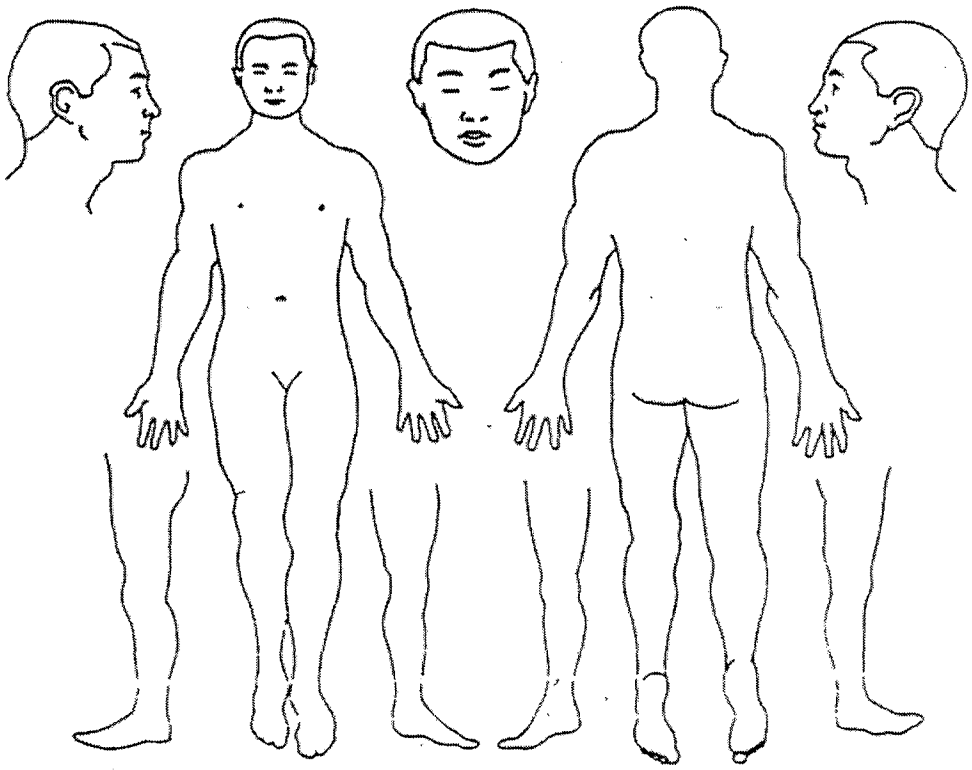
☐ Coffee, Tea Cups per day _____ ☐ Soda Amount per day _____

☐ Cigarettes Packs per day _____ ☐ Stress Cause _____

☐ Recreational drugs Type & frequency of use _____

☐ Alcohol Type & frequency of use _____

Indicate painful or distressed areas:



Please check if you have had (in the last three months):

General		
☐ Poor Appetite	☐ Poor Sleeping	☐ Fatigue
☐ Fevers	☐ Chills	☐ Night Sweats
☐ Sweat easily	☐ Tremors	☐ Cravings
☐ Localized weakness	☐ Poor Balance	☐ Change in appetite
☐ Bleed or bruise easily	☐ Weight loss (unintentional)	☐ Weight gain
☐ Sudden energy drop (what time of day?)		
☐ Do you feel warm or cool?	[warm]	[cool]
☐ Prefer hot or cold liquids?	[hot]	[cold]
☐ How much water do you drink daily?		

Skin & Hair		
☐ Rashes	☐ Hives	☐ Itching
☐ Eczema	☐ Dry Skin	☐ Loss of Hair
☐ Recent Moles	Other hair or skin problems?:	

Head, Eyes, Ears, Nose, Throat		
☐ Dizziness	☐ Eye strain	☐ Eye pain
☐ Poor vision	☐ Night blindness	☐ Cataracts
☐ Blurry vision	☐ Earaches	☐ Ringing in ears
☐ Poor hearing	☐ Spots in front of eyes	☐ Sinus problems
☐ Nose bleeds	☐ Recurrent sore throat	☐ Teeth problems
☐ Facial pain	☐ Sores on lips or tongue	☐ Headache
☐ Any other head or neck problems?		

Cardiovascular		
☐ High blood pressure	☐ Low blood pressure	☐ Chest pain
☐ Irregular Heartbeat	☐ Dizziness	☐ Fainting
☐ Cold hands or feet	☐ Swelling hands	☐ Swelling of feet
☐ Blood clots	☐ Phlebitis	☐ Difficulty in breathing
☐ Any other heart or blood vessel problems?		

Respiratory		
☐ Cough	☐ Coughing blood	☐ Asthma
☐ Pain with a deep breath	☐ Difficulty breathing when lying down	
☐ Production of phlegm	What color?	
☐ Any other lung problems?		

Gastrointestinal		
☐ Nausea	☐ Vomiting	☐ Diarrhea
☐ Constipation	☐ Gas	☐ Belching
☐ Indigestion	☐ Bad Breath	☐ Rectal pain
☐ Hemorrhoids	☐ Abdominal pain or cramps	☐ Chronic laxative use
Any other problems with your stomach or intestines?		
Genito-Urinary		
☐ Pain on urination	☐ Frequent urination	☐ Blood in urine
☐ Urgency	☐ Kidney stones	☐ Decrease in flow
Do you wake up to urinate?	How often?	
Any other problems with your genital or urinary system?		
Pregnancy & Gynecology		
Number of pregnancies	Number of births	Premature births
Miscarriages	Abortions	Age at first menses
Length of cycle	☐ Painful periods	☐ Irregular periods
☐ Vaginal discharge	☐ Vaginal sores	☐ Beast lumps
☐ PMS	Do you practice birth control?	
Any other gynecological problems?		
Musculoskeletal		
☐ Neck pain	☐ Muscle pains	☐ Knee pain
☐ Back pain	☐ Muscle weakness	☐ Foot/ankle pains
☐ Hand/wrist pains	☐ Shoulder pain	☐ Hip pain
Any other joint or bone problems?		
Neuropsychological		
☐ Dizziness	☐ Loss of balance	☐ Areas of numbness
☐ Concussion / Head injury	☐ Lack of coordination	☐ Poor memory
☐ Depression	☐ Anxiety	☐ Bad temper
☐ Easily susceptible to stress		
Have you ever been treated for emotional problems?		
Have you ever considered or attempted suicide?		
Any other neurological or psychological problems?		

Any other information you'd like to share: _____