HEALTH HISTORY QUESTIONNAIRE

Name______________________________ **Date**______________________________
Street City State/Zip____
Home Phone_______________ **Work/Cell Phone**________________ **Email** __________________
Age ____**Date of Birth** ________ **Male**____ **Female**____ **Height**_____ **Weight**____________________
Marital Status: □ Married □ Partnered □ Single □ Widowed □ Divorced or Separated
Education: □ Grammar School □ High School □ College □ Masters □ Doctorate
Occupation __________________ **Retired** ________**Disabled** ______**Unemployed**__________________
Family Physician __________________________**Referred by** __________________________
Emergency Contact Name ______________________**Phone** ____________________________
Emergency Contact Relation to you ____________________________________
How did you hear about us? ____
Have you ever been treated by acupuncture or Oriental medicine before? □ Yes □ No
Main problem you would like us to help you with ______________________________

How long ago did this problem begin? Please be specific:

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

What other kinds of treatment have you tried? □ Western Medicine □ Acupuncture
□ Herbs □ Massage □ Physical Therapy □ Chiropractor □ Reiki □ Homeopathy
□ Other:____
Secondary Complaints you would like us to help you with:

Past Personal Medical History of Significant Illnesses: □ Asthma □ Allergies □ Diabetes □ Cancer □ Stroke
□ Heart disease □ High Blood Pressure □ Seizures □ Hepatitis □ Rheumatic Fever □ Thyroid disease □ Venereal disease □
Other:____

Hospitalizations/Surgeries (including dates) ______________________________

S**ignificant Trauma (auto accidents, falls, etc.**) ______________________________

Allergies (drugs, chemicals, metals, foods) ______________________________

Family Medical History: (check all that are applicable) □ Asthma □ Allergies □ Diabetes □ Cancer □ Stroke □ Heart disease
□ High Blood Pressure □ Seizures □ Thyroid □ Hepatitis □ Rheumatic Fever □ Thyroid disease □ Venereal disease
□ Other: ____
Medicines taken within the last two months (vitamins, drugs, herbs, etc.) ________________________

Are there any areas of your life that you find stressful? Please describe:

Do you have a regular exercise program? □ **No** □ **Yes** If yes, please describe: ____________________

Do you follow any type of special diet (e.g. vegetarian, vegan, medical related, or other)?
□ **No** □ **Yes If Yes, what type of diet?** ______________________________
Describe your average daily diet:
Morning: ____
Afternoon: ____

Evening: ___

Do you smoke? □ No □ Yes If Yes, how many cigarettes or cigars per day? ___
How many cups of caffeinated coffee, tea, or cola do you drink per week? ___
How many 8 oz. glasses of water do you drink per day? ___
How many alcoholic beverages do you drink per week? ___
Please describe any use of drugs for non-medical purposes: ___

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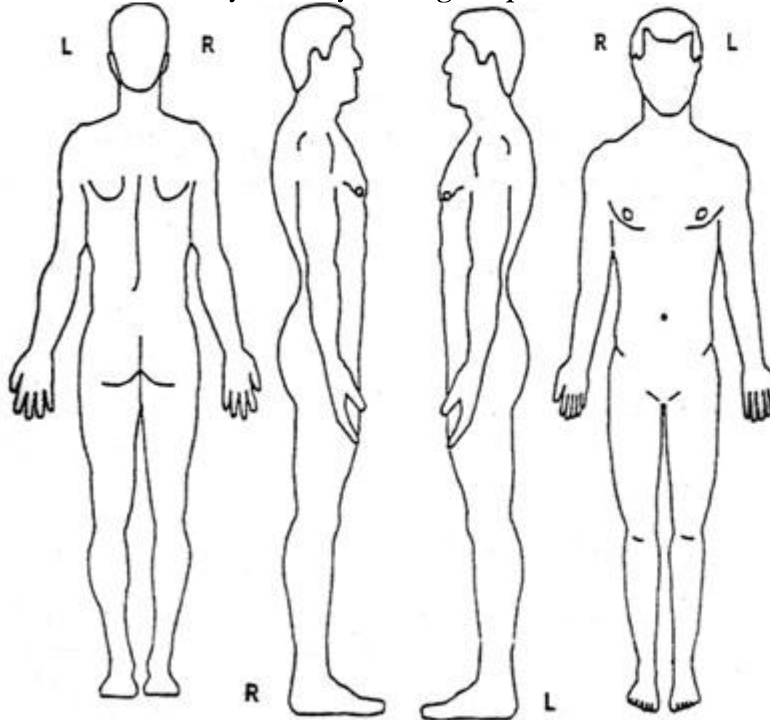
Please indicate any painful or distressed body areas by circling the particular area:



Please check if you have had any of the following, particularly if in the last three months:

GENERAL:
□ Fevers □ Chills □ Fatigue □ Sweat easily □ Poor sleeping □ Night sweats □ Weight loss □ Cravings □ Weight gain
□ Change in appetite □ Strong thirst for: □ Hot drinks □ Cold drinks
□ Sudden energy drop, if so what time of day? ___
□ Bleed or bruise easily □ Peculiar tastes or smells

SKIN & HAIR:
□ Rashes □ Ulcerations □ Hives □ Itching □ Eczema □ Pimples □ Dandruff □ Loss of hair □ Recent moles □ Psoriasis
□ Dermatitis □ Acne □ Change in hair or skin texture □ Any other skin or hair 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 problem □ Nose bleeds □ Recurrent sore throats □ Grinding teeth □ Clenching jaw □ Facial pain
□ Sores on lips or tongue □ Teeth problems □ Jaw clicks □ Headaches, where and how often? ___
□ Any other head or neck problems? ___

CARDIOVASCULAR:
□ High blood pressure □ Low blood pressure □ Chest pain □ Fainting □ Irregular heart beat □ Difficulty in breathing
□ Blood clots □ Phlebitis □ Cold hands or feet □ Swelling of hands □ Swelling of feet □ Varicose or spider veins
□ Palpitations □ Palpitations at rest □ Any other heart of blood vessel problems?___

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 reflux/GERD
□ Hernia □ Excessive appetite □ Poor appetite □ IBS/Crohn's disease □ Colitis □ Slow digestion □ Abdominal pain/cramps
□ Chronic laxative use □ Loose stools, more than 2 per day
□ Any other problem with stomach or intestines____

URINARY:
□ Frequent urination □ Blood in urine □ Pain upon urination □ Urgency to urinate □ Unable to hold urine □ Kidney stones
□ Decrease in flow □ Any particular color to your urine? ____
□ Do you wake up at night to urinate? If yes, how many times a night? ____
□ Any other problems with urinary system? ____

REPRODUCTIVE & GYNECOLOGIC:
(Women)
Are you pregnant? □ Yes □ No
Is it possible that you are pregnant? □ Yes □ No
Number of pregnancies: _______ Live Births:_______ Miscarriages: _______Abortions: _______ Premature births: _______
Age at first menses: _______ Time period between menses: _______ Duration of menses: _______ Last PAP:____________
□ Irregular period □ Painful periods □ Clots □ Breast lumps □ Vaginal sores □ Vaginal discharge □ Vaginal dryness
□ Endometriosis □ Uterine fibroids □ Polycystic Ovarian disease □ Fibrocystic breast tissue □ Hysterectomy
□ Unusual character of blood (heavy, scanty)____
Do you practice birth control? □ Yes □ No If yes, what type? __________________________ How long? ______________
□ Syphilis □Herpes □ Gonorrhea
□ Any other gynecological problems? ____

(Men)
□ Decreased Sexual Drive □ Erectile dysfunction □Premature ejaculation □ Discharge □ Prostate Disease □ Testicular masses
□ Testicular pain □ Vasectomy □ Hernia □ Jock itch □ Syphilis □Herpes □ Gonorrhea
□ Any other problems with sexual health? ____

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_____ Middle______ Upper_____ □ Soreness/weakness of lower body (back, hip, knee, ankle, foot)

NEUROLOGICAL & PSYCHOLOGICAL:
□ Seizures □ Dizziness □ Loss of balance □ Concussion □ Areas of numbness □ Poor memory □ Poor concentration
□ Poor coordination □ Bad temper □ Anger □ Irritability □ Worry □ Obsessive thinking □ Nervousness □ Fidgety □ ADD/ADHD
□ Joy □ Sadness or Grief □ Depression □ Fear □ Timid/Shy □ Indecision □ Anxiety □ Easily susceptible to stress
□ Mood Swings □ 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?____
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COMMENTS: Please tell us briefly of any other problems you would like to discuss.

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