HEALTH QUESTIONNAIRE

Name: _____ Age: _____ Weight: _____ Height: _____ Date Today: _____

When was your last physical exam? _____ Do you have a pacemaker? Yes No

Have you had acupuncture before? Yes No Have you had Chinese herbal medicine before? Yes No

Please describe your current health problem (s): _____

_____

How and when it began: _____

How often are symptoms present? a) constantly b) frequently 3) intermittently 4) occasionally

Are the symptoms: a) improving b) getting worse c) about the same

Factors that make it worse: _____

Factors that make it better: _____

Can you perform your daily activities? a) Yes, all activities b) Some activities c) Not at all

Have you received a diagnosis for this problem? No Yes - Diagnosis: _____

What type of tests/x-rays have been done? _____

What treatment have you already received for this complaint? _____

MEDICAL HISTORY (check all that apply):

Past	Present		Past	Present		Past	Present	
☐	☐	AIDS/HIV	☐	☐	Fatigue	☐	☐	PMS
☐	☐	Abortion	☐	☐	Frequent urination	☐	☐	Pneumonia
☐	☐	Abnormal menstruation	☐	☐	Headache	☐	☐	Poor appetite
☐	☐	Acid reflux	☐	☐	Heart disease/attack	☐	☐	Pregnancy
☐	☐	Addiction	☐	☐	Heartburn/indigestion	☐	☐	Prostate problems
☐	☐	Allergies	☐	☐	Hepatitis	☐	☐	Sinusitis/rhinitis
☐	☐	Anxiety/depression	☐	☐	Herpes	☐	☐	Stroke
☐	☐	Arthritis	☐	☐	High blood pressure	☐	☐	Surgical implants
☐	☐	Asthma	☐	☐	IBS/colon problems	☐	☐	Thyroid disorder
☐	☐	Blood disorder	☐	☐	Joint pain	☐	☐	Ulcers
☐	☐	Cancer/tumor	☐	☐	Kidney problems	☐	☐	Weight gain/loss
☐	☐	Convulsions/seizures	☐	☐	Liver problems	☐	☐	Other: _____
☐	☐	Diabetes	☐	☐	Muscle pain/spasm			_____
☐	☐	Diarrhea/constipation	☐	☐	Nausea			_____
☐	☐	Excessive thirst	☐	☐	Numbness			
☐	☐	Fainting/dizziness	☐	☐	Painful menstruation			

Please list any medications you are taking, the dosage, reason for taking and date you started:

Medication	Dosage	Reason	Date Started

Please list any surgeries or traumatic injuries and their dates

_____

_____

Family history - please circle if a family member has had any of the following and write relationship next to condition:

Autoimmune disease	Cancer	High blood pressure	Other: _____
Arthritis	Diabetes	Mental illness	_____
Asthma	Heart disease	Stroke	