Health History Questionnaire

Narberth Acupuncture   954 Montgomery Ave Suite 7 Narberth PA 19072
Center for Alternative Therapies   935 N Hanover St Pottstown PA 19464
610 668 1114

Important: Complete this document as thoroughly as possible. Some of the questions that follow may seem unrelated to your condition, but they may play a major role in diagnosis and treatment. Please bring this questionnaire and any recent medical tests to your Initial Evaluation.

All information is strictly confidential.

I. General Patient Information

Date: ____/____/____Name: ____

Address: ____

City, State, Zip Code: ____

Home Phone: ______________________ Cell Phone: ______________________

Email:______________________________ ☐ Yes, it is ok to *occasionally* email me with clinic updates, etc. My information will remain private.

Age: _________ Date of Birth: _____/_____/______ Place of Birth:______________________

Guardian (if under 18): ____

Gender: M F Height: ______'______" Weight: ___________lbs. Blood Type______________

Occupation:______________________Employer:______________________

Employer Address:______________________City, State, Zip______________________

How did you hear about our office? ____

Other physicians/ therapists seen for this condition:______________________________

Medications (if any):____

Prescribed by:____

Supplements (any vitamins, herbs, mineral, etc.)______________________________

____

____

Health Care Providers you regularly see (primary care, chiropractors, therapists, bodywork practitioners, etc.)

Please list names, addresses, & phone numbers.

____

____

____

Major Complaint(s), in order of significance to you:

	Severe	Moderate	Slight	Normal	
1.	☐	☐	☐	☐	
2	☐	☐	☐	☐	
3.	☐	☐	☐	☐	
4	☐	☐	☐	☐	
5.	☐	☐	☐	☐	
6.	☐	☐	☐	☐	
7.	☐	☐	☐	☐	
8.	☐	☐	☐	☐	
9.	☐	☐	☐	☐	
10.	☐	☐	☐	☐	

How do these conditions impair your daily activities?______________________________

____

____

____

II. Patient Medical History

How was your childhood health?____

____

Hospital Visits/ Stays:____

____

____

____

Recent tests: (please indicate test results and date below)

☐ Physical ☐ Cholesterol ☐ Prostate ☐ Blood (which?)

☐ HIV/STD ☐ Pap smear ☐ Mammography ☐ Other:__________________

Test Results and Date:____

____

____

Check any you have had in the past:

☐ Diabetes	☐ Allergies	☐ Glaucoma	☐ Rheumatic Fever
☐ Heart Disease	☐ CVA (stroke)	☐ Vein condition	☐ Thyroid disorder
☐ Asthma	☐ Pneumonia	☐ Tuberculosis	☐ Emphysema
☐ Jaundice	☐ Gonorrhea	☐ Mumps	☐ Bleeding tendency
☐ Syphilis	☐ Measles	☐ Chicken pox	☐ Nervous disorder
☐ Meningitis	☐ HIV	☐ Polio	☐ Mononucleosis
☐ Epilepsy	☐ High fever	☐ Hepatitis	☐ Multiple Sclerosis
☐ Paralysis	☐ Cancer	☐ Migraines	☐ High blood pressure

☐ Other:____

Immunizations:____

Surgeries:____

____

____

III. Family History

Family Member	Alive	Deceased	Present Health or Cause of Death
Father	☐	☐	
Mother	☐	☐	
Spouse	☐	☐	
Child	☐	☐	
Child	☐	☐	
Child	☐	☐	
Child	☐	☐	
Sibling	☐	☐	
Sibling	☐	☐	
Sibling	☐	☐	
Sibling	☐	☐	
Sibling	☐	☐	

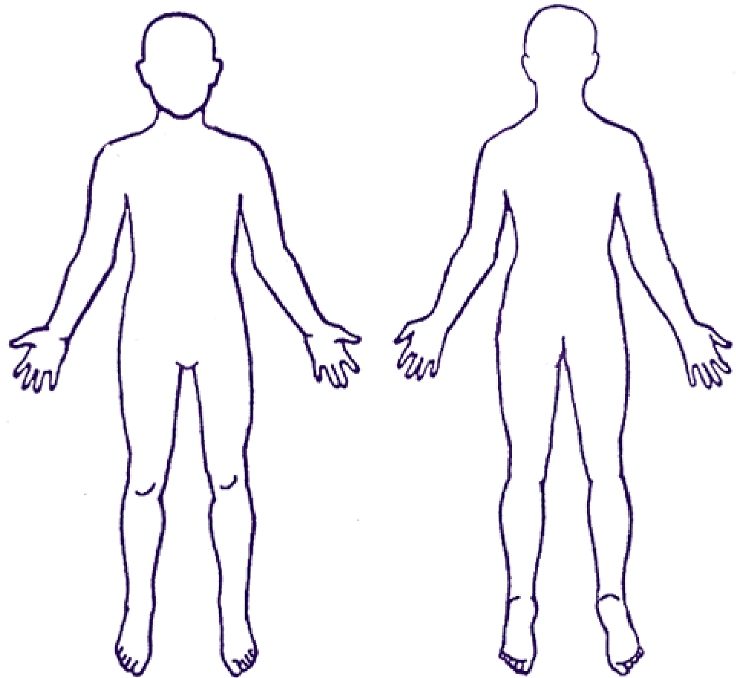
Where are you in the birth order? ☐ First ☐ Middle ☐ Only

Check the following that have occurred in your blood relatives:

☐ Diabetes	☐ Cancer	☐ Heart disease	☐ High blood pressure
☐ Allergies	☐ Tuberculosis	☐ Obesity	☐ Bleeding tendency
☐ Kidney disease	☐ Alcoholism	☐ Nervous illness	☐ Mental illness
☐ Stroke	☐ Other ________________		

IV. Patient Profile

Please clearly mark any areas of pain and any scars (please indicate which of the areas are scars):



Is the pain:

☐ Sharp ☐ Burning ☐ Aching
☐ Cramping ☐ Dull ☐ Moving
☐ Fixed ☐ Other:___________________

Do the following lessen the pain?

☐ Pressure ☐ Cold ☐ Heat
☐ Exercise
☐ Other:__________________

Do the following worsen the pain?

☐ Pressure ☐ Cold ☐ Heat
☐ Other:____________________________

Please check the following that currently pertain to you.

Overall Temperature (Kidney function):

☐ Cold hands
☐ Cold feet
☐ Sweaty hands
☐ Sweaty feet
☐ Hot body temperature (sensation)
☐ Cold body temperature (sensation)
☐ Afternoon flushes
☐ Night sweats
☐ Heat in the hands, feet, and chest
☐ Hot flashes any time of the day
☐ Thirsty
☐ Perspire easily
☐ Lack of perspiration
☐ Take water to bed
☐ Difficulty keeping eyes open in the daytime

Overall energy (Lung, Kidney function):

☐ Shortness of breath
☐ Difficulty keeping eyes open in the daytime
☐ General weakness
☐ Easily catch colds
☐ Low energy
☐ Feel worse after exercise

Blood (Liver, Spleen, Heart function):

☐ Dizziness
☐ See floating black spots

Heart function:

☐ Palpitations
☐ Anxiety
☐ Sores on the tip of the tongue
☐ Restlessness
☐ Mental confusion
☐ Chest pain traveling to shoulder
☐ Frequent dreams
☐ Wake unrefreshed
☐ Drink coffee (# of cups per week: _______)

Lung function:

☐ Nasal Discharge (Color: ________________)
☐ Cough
☐ Nose Bleeds
☐ Sinus Congestion
☐ Dry mouth
☐ Dry throat
☐ Dry Nose
☐ Dry Skin
☐ Allergies
(To what? ____________________________)
☐ Alternating fever and chills
☐ Sneezing
☐ Headache
(Location: ____________________________)
☐ Overall achy feeling in the body
☐ Stiff neck
☐ Stiff shoulders
☐ Sore throat
☐ Difficulty breathing
☐ Smoke cigarettes
(# of cigarettes per day: ________________)
☐ Sadness
☐ Melancholy

Spleen function:

☐ Low appetite
☐ Abrupt weight gain
☐ Abrupt weight loss
☐ Abdominal bloating
☐ Abdominal gas
☐ Gurgling noise in the stomach
☐ Fatigue after eating
☐ Prolapsed organs (previously diagnosed, Which organ? __________________________)
☐ Easily bruised
☐ Hemorrhoids
☐ Pensive
☐ Over-thinking
☐ Worry

Spleen, Stomach, Large Intestine, Small Intestine function:

☐ Loose
☐ Constipated
☐ Incomplete
☐ Diarrhea
☐ Blood in stools
☐ Mucous in stools
☐ Undigested food in stools

Dampness trapped in the body:

☐ General sensation of heaviness in the body
☐ Mental heaviness
☐ Mental sluggishness
☐ Mental fogginess
☐ Swollen hands
☐ Swollen feet
☐ Swollen joints
☐ Chest congestion
☐ Nausea
☐ Snoring

Stomach function:

☐ Burning sensation after eating
☐ Large appetite
☐ Bad breath
☐ Mouth (canker) sores
☐ Bleeding, swollen or painful gums
☐ Heartburn
☐ Acid regurgitation
☐ Ulcer (diagnosed)
☐ Belching
☐ Hiccoughs
☐ Stomach pain
☐ Vomiting

Liver, Gall Bladder function:

☐ Alternating diarrhea and constipation
☐ Chest pain
☐ Tight sensation in the chest
☐ Bitter taste in the mouth
☐ Anger easily
☐ Frustration
☐ Depression
☐ Irritability
☐ Frequently unable to adapt to stress
(What causes the stress? ____)
☐ Skin rashes
☐ Headache at the top of the head
☐ Tingling sensation
☐ Numbness
☐ Muscle spasms
☐ Muscle twitching
☐ Muscle cramping
☐ Seizures
☐ Convulsions

☐ Lump in the throat
☐ Neck tension
☐ Limited Range-of-Motion, Neck
☐ Shoulder tension
☐ Limited Range-of-Motion, Shoulder
☐ Drink alcohol
☐ Recreational drugs
(Which? ___________________________,
How much per week? ______________)
☐ High-pitched ringing in the ears
☐ Gall stones (history or current)
☐ Sexually transmitted disease
(Which? ___________________________)

Eyes (Liver function):
☐ Itchy
☐ Bloodshot
☐ Hot
☐ Dry
☐ Watery
☐ Gritty
☐ Blurry vision
☐ Decreased night vision
☐ Near-sighted
☐ Far-sighted

Kidney, Urinary Bladder function:
☐ Frequent cavities
☐ Easily broken bones
☐ Sore knees
☐ Weak knees
☐ Cold sensation in the knees
☐ Low back pain
☐ Memory problems
☐ Excessive hair loss
☐ Low-pitched ringing in the ears
☐ Kidney stones
☐ Bladder infections
☐ Wake during the night twice or more to urinate
☐ Lack of bladder control
☐ Fear
☐ Easily startled

Urination:
☐ Normal color
☐ Dark yellow
☐ Clear
☐ Reddish
☐ Cloudy
☐ Scanty
☐ Profuse
☐ Strong odor
☐ Burning
☐ Painful
☐ Discharge
☐ Difficult
☐ Painful
☐ Urgent
☐ Frequent

Libido:
☐ Normal
☐ High
☐ Low

Other symptoms:____

____

____

Other Comments:____

____

____

____

____

Women only:

Regular menstrual cycle? ☐ Y ☐ N Pregnant? ☐ Y ☐ N

Number of children:________________ Number of pregnancies:___________________

Age of first menstruation:___________ Age of menopause (if applicable):___________

Average number of days of flow:______ Average number of days of entire cycle:_____

	Severe	Moderate	Slight	Normal
Vaginal Discharge	☐	☐	☐	☐
Bleeding between periods	☐	☐	☐	☐

Do you experience any of the following pre-menstrual syndromes?

☐ Nausea ☐ Vomiting ☐ Water retention ☐ Breast swelling
☐ Food cravings ☐ Headaches ☐ Migraines ☐ Breast tenderness
☐ Depression ☐ Irritability ☐ Anxiety
☐ Other emotions:____

☐ Dull pain, where?____________________ ☐Sharp pain, where?______________________________

Please fill in the following menstrual chart:

	Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7
Color (normal, bright red, pale, brown, rust, dark, purple, other)							
Amount of flow (normal, heavy, light)							
Pain/cramps (location, dull, sharp, other)							
Clots (large, small, black, purple, red, other)							
Vomiting (check if yes)							
Nausea (check if yes)							
Other							

Men only:

☐ Swollen testes ☐ Testicular pain ☐ Impotence ☐ Premature ejaculation
☐ Feeling of coldness or numbness in external genitalia
☐ Other____

Traditional Acupuncture
Chinese Herbal Medicine

Ruth E. Fletcher, R.Om., M.Ac., Dipl. Ac.
954 Montgomery Ave. Suite 7
Narberth, PA 19072
610-668-1114

CONSENT

Possible Side Effects/Healing Reactions

I understand that acupuncture may result in certain side effects, including local bruising, slight bleeding, fainting, temporary pain or discomfort, and temporary aggravation of symptoms existing prior to treatment. Conventional medical therapy also may be indicated, either in response to an emergency or as deemed necessary in the discretion of a licensed physician.

Medical Referral

I understand that if there is a worsening of my ailment or condition, or if it does not improve within the time estimated by the acupuncturist at the beginning of treatment, or if a new condition arises, that I should consult a licensed physician.

Infectious Disease/Clean Needle Procedures

I understand that there is infectious disease carried through the air, through physical contact, and through body fluids. I understand that Ruth Fletcher, Registered Acupuncturist, follows universally prescribed precautions to guard against the spread of infection.

In the case of blood-borne infections, such as hepatitis or HIV, I understand that the practitioner, Ruth Fletcher, follows strict precautions. The practitioner uses only sterilized prepackaged, disposable needles. Needles that are used for my treatment are used only on me, and are inserted according to clean procedures based on nationally prescribed standards.

I understand that my questions about the safety of acupuncture and the precautions taken by my practitioner are most welcome and will be answered as fully as possible.

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Signature

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Cancellation Policy

In today's hectic world unplanned issues (or events) come up for all of us. If you need to cancel an appointment, please do so a minimum of 24 hours in advance so that others needing treatment can take advantage of an open time slot. If you do not cancel 24 hours in advance, you will be charged a $50.00 missed appointment fee which will be collected at the time of your next treatment. My intention is not to collect missed appointment fees but to provide timely treatments for all my clients. Your cooperation and consideration are greatly appreciated.

Signed(patient signature): ____

Date: _______________________________________