Prairie Spring Acupuncture Clinic
Health History Questionnaire

Date_______________

Please help us provide you with a complete evaluation by taking the time to fill out this questionnaire carefully. All of your answers will be held absolutely confidential. If you have any questions, please ask.

Name____ Date of Birth___________ Age________

Gender: ☐ Male ☐ Female ☐ Transgender ☐ Intersex Email Address ______________________________

Address____ City_________________ State_____ Zip__________

Home Phone_______________________ Work Phone_____________________ Cell Phone___________________

Height_______________ Weight________________ Occupation____

Family Physician_____________________ Last seen (date)______________

Referred by: Friend/Relative_________________________ Internet Search ____________________________________

Relationship status (optional) ☐ Single ☐ Married/Partnered ☐ Separated ☐ Divorced ☐ Widowed
Spouse/Partner Name______________________________ Cell or Work Phone______________________________

Emergency Contact_____________________________ Emergency Contact Phone___________________________

Have you been treated by Acupuncture or Chinese Medicine in the past? ☐ Yes ☐ No

What is/are the main problem(s) you would like help with? ____
____

How long ago did this problem begin?____

To what extent does this problem interfere with your daily activities? _____________________________________
____

Have you been given a diagnosis for this problem? If so, what? By whom?__________________________________
____

What kinds of treatment have you tried?____

Your Past/Current Medical History:
(please include date)

☐ Cancer______	☐ High Blood Pressure_____	☐ Thyroid Disease_______
☐ Seizures_____	☐ Rheumatic Fever________	☐ Heart Disease_________
☐ Hepatitis_____	☐ Venereal Disease_______	☐ Diabetes____________
☐ HIV_________	☐ Asthma/Pneumonia______	☐ Anemia______________

Family Medical History:

☐ Cancer______	☐ High Blood Pressure_____	☐ Thyroid Disease_______
☐ Seizures_____	☐ Heart Disease__________	☐ Diabetes____________
☐ Anemia_____	☐ Asthma_______________	☐ Hepatitis____________

☐ Other_________

Other (include chronic illnesses) ____
____

Surgeries (type of and date)____
____

Any recent medical procedures____

Significant trauma or hospitalizations (auto accidents, falls, concussions, etc.)_____________________________

Are you on antibiotics now or have you used antibiotics in the past 3 months? If so, which antibiotics have you taken?

Are you currently pregnant?______________________________ What is your due date?________________________________

Allergies (drugs, chemicals, foods) and your reaction to them ____

Occupational Stress (chemical, physical, psychological, etc.)____

Do you have a regular exercise program? ☐ Yes ☐ No Please describe____________________________________

Have you ever been on a restricted diet? ☐ Yes ☐ No Please describe____________________________________

Please describe your average daily diet:

Morning____

Afternoon____

Evening____

Do you smoke? ☐ Yes ☐ No How many packs per day?__________ How long have you smoked? _______________

How much coffee, tea or cola do you drink per week? Coffee______________ Tea______________ Cola_______________
How many energy drinks do you drink per week? ____
How much alcohol do you drink per week?____
Describe any use of drugs for non-medical purposes____

Are you a Vegan? ☐ Yes ☐ No For how long? _________________
Are you a Vegetarian? ☐ Yes ☐ No For how long? _________________

Please rate the following regarding your relationships and lifestyle:

	Great	Good	Fair	Poor	Bad	Comments
Spouse						
Family						
Living Situation						
Diet						
Sex Life						
Self						
Work						
Exercise						
Spirituality						
Other						

Please check any symptoms you have had in the last three months:

General
__ Pain: Where:_____________
Level (1 - 10)________
__ Energy level (1 - 10)________
__ Sudden energy drop
Time of day__________
__ Localized weakness
Where______________
__ Fatigue
__ Poor sleep
__ Sleep disorder
__ Fevers
__ Chills
__ Sweat easily
__ Night sweats
__ Bleed or bruise easily
__ Edema
Where?_____________
__ Tremors
__ Poor balance
__ Weight Gain
__ Weight Loss

Head, Eyes, Ears, Nose & Throat
__ Dizziness
__ Migraines
__ Headaches?
When?__________________
Where?_________________
__ Facial Pain
__ Glasses
__ Poor vision
__ Night blindness
__ Blurry vision
__ Color Blindness
__ Blind field
__ Spots in front of eyes/floaters
__ Eye Pain
__ Eye Strain
__ Cataracts
__ Eye dryness
__ Excessive tear
__ Discharge from eyes
__ Poor hearing
__ Ringing in ears
__ Earaches
__ Discharge from ear
__ Hearing aide
__ Nose Bleeds
__ Sinus congestion
__ Nasal drainage
__ Loss of consciousness
__ Grinding teeth
__ Teeth problems
__ Jaw clicks
__ Concussions
__ Recurrent sore throats
__ Hoarseness
__ Sore on lips or tongue

Other head or neck problems?
____

Skin and Hair
__ Rashes
__ Itching
__ Change in hair or skin
__ Ulcerations
__ Eczema
__ Oozing or skin lesion
__ Hives
__ Pimples
__ Recent moles
__ Loss of hair
__ Dandruff
__ Foot fungus
Other hair, skin or foot problems?
____

Cardiovascular
__ High blood pressure
__ Low blood pressure
Your normal blood pressure reading:____________________
__ Chest discomfort/pain
__ Heart Palpitations
__ Cold hands or feet
__ Swelling of hands
__ Swelling of feet
__ Blood clots
__ Fainting
__Other heart or blood vessel problems?_________________
____

Respiratory
__ Allergies
__ Cough
__ Asthma/wheezing
__ Pain with a deep breath
__ Shortness of breath
__ Difficulty inhaling
__ Difficulty exhaling
__ Production of phlegm
What color?________________
__ Coughing blood
__ Pneumonia
__ Bronchitis
__ Other lung problems?________
____

Musculo-Skeletal
__ Neck pain
__ Shoulder pain
__ Back pain
__ Elbow pain
__ Hand/wrist pain
__ Hip pain
__ Knee pain
__ Foot/ankle pain
__ Muscle pain
__ Muscle weakness
__ Other muscular/skeletal problems?
____
____
____

Urinary
__ Pain on urination
__ Urgency to urinate
__ Frequent urination
__ Profuse urination
__ Retention of urination
__ Blood in urine
__ Decrease in flow
__ Dribbling
__ Kidney stones
__ Do you wake up to urinate?
Yes___ No___
How often? _________
Urine any particular color?
____
__ Urinary tract infections
__Other genital /urinary systems problems?____________________

Diet/Gastrointestinal
__ Peculiar taste or smells
__ Strong thirst (cold or hot)
__ Thirst, no desire to drink
__ Cravings? For what?_________
__ Change in appetite
__ Poor appetite
__ Bad Breath
__ Digestive Allergies
__ Nausea
__ Vomiting
__ Heartburn
__ Belching
__ Indigestion
__ Diarrhea
__ Constipation
__ Chronic laxative use
__ Blood in stools
__ Black stools
__ Abdominal pain or cramps
__ Abdomen tense or firm
__ Abdominal distention
__ Epigastric pain
__ Pain better__ or worse__ with pressure
__ Gas
__ Rectal pain

__ Hemorrhoids
Other stomach or intestinal problems?
____
____
____

Psycho-emotional
__ Insomnia
__ Irritability
__ Loss of control/violence potential
__ Depression
__ Easily susceptible to stress
__ Anxiety
__ Substance abuse
__ Have you ever considered or attempted suicide?
Yes___ No___
__ Bipolar Disorder
__ Post Traumatic Stress Disorder
__ Claustrophobia
__ Panic Attacks
__ Currently under the care of therapist/psychiatrist
__ Previously under the care of therapist/psychiatrist

Neurological
__ Seizures
__ Areas of numbness
__ Weakness
__ Concussion(s)
How many? __________
__ Loss of consciousness
__ Vertigo or dizziness
__ Lack of coordination
__ Loss of balance
__ Poor memory

Sexual/Genital
__ Changes in sexual drive
__ Sores on genitals
__ Pain in genital area
Do you consider your libido normal for your age? Yes__ No__
Too high__ Too low__

Female
__ Age of first menses __________
__ Days between menses _______
__ Number of Days __________
__ Heavy periods __ Light periods
Color of blood:
__ Bright red __ Normal red
__ Purple __ Dark Brown
__ Painful periods
__ Irregular periods
__ Moodiness
__ Cramps
__ Bloating
__ Low back pain
__ Clots
__ Menopause
Age_____ Year_____
__ Vaginal discharge
__ Postcoital bleeding
__ Vaginal sores
__ Date of last pap smear _______
__ Breast lumps
__ Nipple discharge
__ Breast cancer
__ Ovarian cancer
__ Uterine cancer
__ Other issues? Yes___ No___
____
____
Date of last Period:
____

Pregnancy
Number of pregnancies______
Number of births____________
Number of premature________
Number of miscarriages______
Number of abortions________
Do you use birth control?
Yes___ No___
What type?___________________

Male
__ Erectile dysfunction
__ Prostate problems
__ Premature ejaculation or wet dreams
__ Vasectomy
__ Prostate cancer
__ Testicular cancer
__ Breast cancer
__ Other issues? Yes___ No____
____

Other
____
____
____
____
____
____
____
____
____

Please note the degree of severity of your main problem now:

No problem Worst imaginable

Please note the greatest degree of severity of your main problem within the last week:

No problem Worst imaginable

If applicable, indicate painful or distressed areas:

Front Back

Comments: (Please indicate any other problem you would like to discuss):

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