Health History Questionnaire

Information for your Acupuncturist

Important: Complete this document as thoroughly as possible. Some of the questions that follow may seem unrealted to your condition, but thye may placy a major role in diagnosis and treatment

All information is strictly confidential

I. General Patient Information

Date: ____ / ____ / ____ Name: _____

Address: _____ City: _____

State: _____ Zip: _____ Email: _____

Home Phone: ( ) _____ Work Phone: ( ) _____ Cell Phone: ( ) _____

Age: _____ Date of Birth: ____ / ____ / ____

Guardian (if under 18): _____

Gender: Male ☐ Female ☐ Height: ____ ' ____ " Weight: _____ Lbs.

Occupation: _____ Employer: _____

Employer Address: _____ City: _____

State: _____ Zip: _____

Does anthing limit you from care? Yes ☐ No ☐ If yes, explain: _____

_____

How did you hear about our office:

Website ☐ Friend or Relative ☐ Please let us know who to thank for referal: _____

Saw a Demo ☐ Other Advertising ☐ _____

Yellow Pages ☐ Other ☐ _____

Other physicians/therapist seen for this condition: _____

Current medications: _____

_____

Prescribed by: _____

Treatment:

Results:

Supplements (if any vitamins, herbs, minerals): _____

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 lung illnesses	❑ other liver illnesses	❑ other heart illnesses	❑ other kidney illnesses
❑ other spleen illnesses		❑ other stomach illnesses	

❑ other:_____

Immunizations:_____

Surgeries:_____

III. Family History

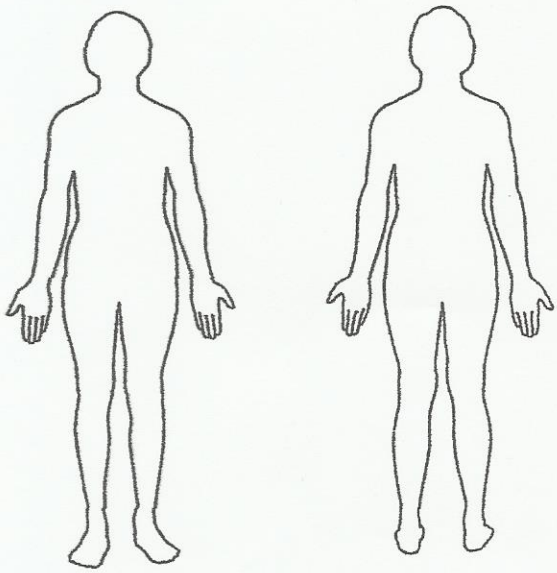
Family member	Alive	Deceased	Present health or cause of death
Father	❑	❑	
Mother	❑	❑	
Spouse	❑	❑	
Children	❑	❑	
Brother	❑	❑	
Brother	❑	❑	
Brother	❑	❑	
Sister	❑	❑	
Sister	❑	❑	
Sister	❑	❑	

Where are you in the birth order? ❑ first ❑ last ❑ 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):



Front Back

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 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:

Women only:

Regular menstrual cycle? ❑ Y ❑ N
Number of children:_____
Age of first menstruation:_____
Average number of days of flow:_____
cycle:_____

Pregnant? ❑ Y ❑ N
Number of pregnancies:_____
Age of menopause (if applicable):_____
Average number of days of entire

	Severe	Moderate	Slight	Normal
Vaginal discharge:	❑	❑	❑	❑
Bleeding between periods:	❑	❑	❑	❑

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

❑ nausea ❑ food cravings ❑ depression ❑ vomiting

❑ headaches ❑ irritability ❑ water retention ❑ migraines

❑ anxiety ❑ breast swelling ❑ breast tenderness

❑ other emotions:_____ ❑ dull pain, where?_____

❑ sharp pain, where?_____

❑ Other: _____

Please fill in the following menstrual chart:
(Put in a number and what color it is)

	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:

	Severe	Moderate	Slight	Normal
❑ Swollen testes	❑	❑	❑	❑
❑ Testicular pain	❑	❑	❑	❑
❑ Impotence	❑	❑	❑	❑
❑ Premature ejaculation	❑	❑	❑	❑
❑ Feeling of coldness or numbness in external genitalia	❑	❑	❑	❑
❑ Other_____	❑	❑	❑	❑

All please fill out:

Other Comments:_____

_____

Patient Signature:_____

Acupuncturist Signature:_____