Health History Questionnaire

Information for your Acupuncturist.

Please complete this document as thoroughly as possible. Some of the questions that follow may seem unrelated to your condition, however, they may play a major role in diagnosis and treatment.

General Patient Information

Date: _____ / _____ / _____

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Email: _____ Would you like to receive our e-mail newsletter? ☐ YES ☐ NO

Age: _____ Date of Birth: _____ / _____ / _____ Place of Birth: _____

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Domestic Partnership ☐ Other

Name of Spouse/Partner/Other: _____

Guardian (if under 18): _____

Gender: ☐ MALE ☐ FEMALE Height: _____ Weight: _____

Social Security Number: _____ Drivers License Number: _____

Occupation: _____ Employer: _____

Employer Address: _____

City: _____ State: _____ Zip Code: _____

Goal from acupuncture or other services we offer: _____

Does anything limit you from care? ☐ NO ☐ YES (explain) _____

How did you hear about our office? _____

Other physicians/therapists seen for this: _____

Medications (if any): _____

Prescribed by: _____

Treatment(s): _____

_____

Results: _____

Supplements/Vitamins/Herbs: _____

_____

Major complaints, in order of significance to you:

	SEVERE	MODERATE	SLIGHT	NORMAL
_____	☐	☐	☐	☐
_____	☐	☐	☐	☐
_____	☐	☐	☐	☐
_____	☐	☐	☐	☐
_____	☐	☐	☐	☐
_____	☐	☐	☐	☐

How do these conditions impair your daily activities? _____

_____

_____

Patient Medical History

How was your childhood health? _____

Hospital Visits/Stays: _____

_____

Recent tests *(indicate results and date below)*

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

☐ HIV/STD ☐ Pap smear ☐ Mammography ☐ Hormone (saliva)

☐ Thermography ☐ 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 Illness	☐ Other Liver Illness	☐ Other Heart Illness	☐ Other Kidney Illness
☐ Other Spleen Illness	☐ Other Stomach Illness		

☐ Other: _____

Immunizations: _____

Surgeries: _____

Family History:

Father	Alive ☐	Deceased ☐	Present Health/Cause of Death
Mother	Alive ☐	Deceased ☐	Present Health/Cause of Death
Spouse	Alive ☐	Deceased ☐	Present Health/Cause of Death
Child	Alive ☐	Deceased ☐	Present Health/Cause of Death
Child	Alive ☐	Deceased ☐	Present Health/Cause of Death
Sibling	Alive ☐	Deceased ☐	Present Health/Cause of Death
Sibling	Alive ☐	Deceased ☐	Present Health/Cause of Death
Sibling	Alive ☐	Deceased ☐	Present Health/Cause of Death

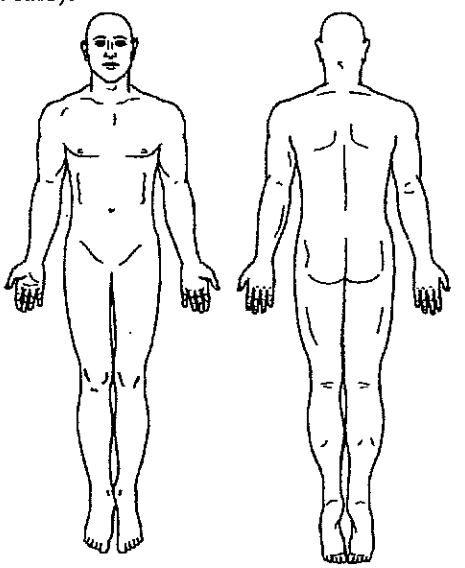
Where are you in the birth order? ☐ First ☐ Last ☐ Middle ☐ Only ☐ Other: _____

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	☐ Unsure	☐ Other: _____	

Patient Profile:

Please clearly mark below any areas of pain and any scars (indicate which 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
☐ Exercise	☐ 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 (#_____ cups/week)
- ☐ Knee pain

LUNG FUNCTION

- ☐ Nasal discharge (color: _____)
- ☐ Cough
- ☐ Nose bleeds
- ☐ Sinus congestion
- ☐ Dry mouth
- ☐ Dry throat
- ☐ Dry nose
- ☐ Dry skin
- ☐ Allergies (to what? _____)
- ☐ Alternating fever/chills
- ☐ Sneezing
- ☐ Headache (location? _____)
- ☐ Overall achy feeling in the body
- ☐ Stiff neck
- ☐ Stiff shoulders
- ☐ Sore throat
- ☐ Difficulty breathing
- ☐ Smoke cigarettes (#_____/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 (which diagnosed?_____)
- ☐ Easily bruised
- ☐ Hemorrhoids
- ☐ Pensive
- ☐ Over-thinking
- ☐ Worry

SPLEEN, STOMACH, LARGE AND SMALL INTESTINE FUNCTION

- ☐ Loose stools
- ☐ Constipated
- ☐ Incomplete stools
- ☐ 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

DAMPNESS TRAPPED IN THE BODY (cont.)

- ☐ 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
- ☐ Thirst with no desire to drink

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
  (caused by? _____)
- ☐ 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 (past or present)
- ☐ 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 sensations 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

KIDNEY, URINARY BLADDER FUNCTION (cont.)

- ☐ Lack of bladder control
- ☐ Fear
- ☐ Easily startled

URINATION

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

LIBIDO

- ☐ Normal
- ☐ High
- ☐ Low
- ☐ Other symptoms: _____

Women Only:

Regular menstrual cycle? ☐ YES ☐ NO Pregnant? ☐ YES ☐ NO

Number of pregnancies: _____ Number of children: _____ Age of 1st menstruation: _____

Age of menopause: _____ Average # of days of flow: _____ Average # of days of cycle: _____

	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? _____
- ☐ other: _____

Please fill out menstrual chart on following page.

Please fill in the following menstrual chart (enter color)	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:	☐	☐	☐	☐
Coldness/numbness in external genitalia:	☐	☐	☐	☐
Other: _____	☐	☐	☐	☐

All patients — please fill out:

Other comments: _____

_____

Patient Signature: _____

Acupuncturist Signature: _____