Health History Questionnaire

Information for your Acupuncturist

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.

All information is strictly confidential.

I. General Patient Information

Date: ____/____/____ Name: _____

Address: _____City_____

State _____Zip_____

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

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

Guardian (if under 18): _____

Gender: [ ] M [ ] F Height: ____'____" Weight: _____lbs.

Social Security Number: _____-_____-_____

Driver's License Number:_____

Occupation:_____Employer:_____

Employer Address: _____City_____

State _____Zip_____

Does anything limit you from care? [ ] Y [ ] N If yes, explain:_____

How did you hear about our office?_____

Other physicians/therapists seen for this condition._____

Medications (if any):_____

Prescribed by:_____

Treatment:

Results:

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

_____

_____

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

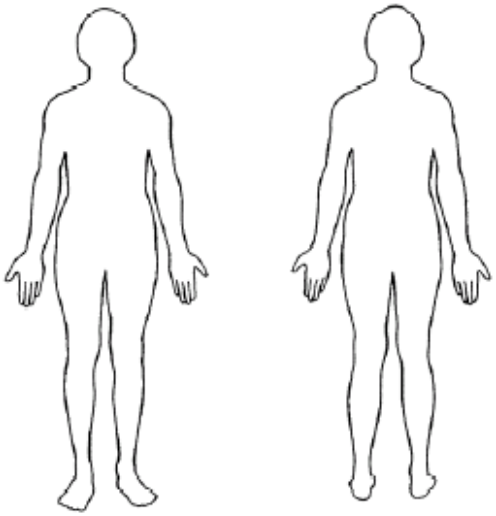
Family member	Alive	Deceased	Present health or cause of death
Father	❑	❑	
Mother	❑	❑	
Spouse	❑	❑	
Children	❑	❑	
Brother	❑	❑	
Brother	❑	❑	
Brother	❑	❑	
Sister	❑	❑	
Sister	❑	❑	
Sister	❑	❑	

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):



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:_____
Average number of days of entire cycle:_____

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

	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: _____

	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:_____