Patient:_____Date:_____
Practitioner: Nadia Johnson, LAc

**PATIENT INFORMATION AND HEALTH HISTORY QUESTIONNAIRE**

**General Information**

Name_____ Date_____

Date of Birth_____Gender_____Marital Status_____

Address_____City_____State_____Zip_____

Email_____Home Phone_____

Mobile Phone_____Guardian_____

Emergency Contact_____Relation to You_____

Emergency Contact Phone_____Occupation_____

Primary Care Physician (PCP)_____PCP Phone_____

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**New Patient Health History**

Chief complaint:_____

_____

_____

_____

Please indicate the severity of this problem at its worst (with 10 being worst)

0 1 2 3 4 5 6 7 8 9 10

Please indicate the severity of this problem at its best (with 0 being no problem)

0 1 2 3 4 5 6 7 8 9 10

When did this problem start:_____

_____

_____

_____

How often do you experience it? Is it constant? Does it come and go? How long are the episodes when you experience it?_____

_____

_____

_____

What makes it better?_____

_____

What makes it worse?_____

_____

Please list a second most important complaint (if you have any)_____

_____

_____

Please indicate the severity of this problem at its worst

0 1 2 3 4 5 6 7 8 9 10

Please indicate the severity of this problem at its best

0 1 2 3 4 5 6 7 8 9 10

For your chief and or secondary complaint(s) please describe any therapies/treatments you have tried or are currently receiving. Please tell us how these treatments are working.

_____

_____

_____

Please note any other problems or concerns you would like to address.

_____

_____

**Please check the applicable boxes. You can give details or add any additional information in the notes box after each section.**

☐ I have a bleeding disorder.
☐ I am currently taking blood thinning medication.
☐ I have an electrical implant such as pacemaker, insulin pump or stimulator.
☐ I am pregnant, may be pregnant or planning to be pregnant.
☐ I have epilepsy.
☐ I have a history of cancer.
☐ I am currently undergoing treatment for cancer.
☐ I am currently undergoing treatment for hepatitis.
☐ Surgical history/hospitalizations.
☐ I have needling restrictions on areas of my body (note below).
☐ Other
☐ None of these apply.

Please give details for any boxes checked above:_____

_____

_____

**Head**

| | | |
|---|---|---|
| ☐ Migraines | ☐ Concussions | ☐ Jaw clenching/grinds teeth |
| ☐ Headaches | ☐ Faintness or Dizziness | ☐ Vertigo |
| ☐ Facial Pain | ☐ TMJ Pain | |

Details for any boxes checked above or other non listed problem:_____

_____

_____

**Skin and Hair**

| | | |
|---|---|---|
| ☐ Normal | ☐ Hives | ☐ Acne |
| ☐ Dry skin | ☐ Rash | ☐ Graying Early |
| ☐ Hair loss | ☐ Eczema | ☐ Wounds slow to heal |
| ☐ Psoriasis | ☐ Itchy skin | ☐ Dry/brittle hair/no lustre |

Details for any boxes checked above or other non listed problem:_____

_____

_____

**Eyes, Ears, Nose, Throat**

☐ Sinus pain
☐ Chronic sinus congestion
☐ Chronic cough
☐ Nasal discharge
☐ Gum or teeth problems
☐ Excessive thirst or dry mouth
☐ Allergies
☐ Watery eyes
☐ Itchy eyes
☐ Red eyes
☐ Dry eyes
☐ Sore Throat
☐ Feeling that something is stuck in throat
☐ Blurry vision
☐ Cataracts
☐ Macular degeneration
☐ Eye pain
☐ Ear pain
☐ Hearing problems
☐ Ringing in ears - high pitched
☐ Ringing in ears - low pitched
☐ Other

Details for any boxes checked above or other non listed problem:_____

_____

**Respiratory/Immunologic**

☐ Asthma
☐ Cough
☐ Chest Congestion
☐ COPD
☐ Emphysema
☐ TB
☐ Fungal infection
☐ Frequent colds
☐ Frequent low grade fever
☐ Chills
☐ Fever
☐ Immunologic disorder
☐ Other

Details for any boxes checked above or other non listed problem:_____

_____

**Cardiovascular/Hematological**

☐ Pacemaker
☐ Normal Blood Pressure
☐ High Blood Pressure
☐ Low Blood Pressure
☐ Irregular Heartbeat
☐ Palpitations
☐ High cholesterol
☐ Ankle swelling
☐ Chest pains
☐ Cold Hand and/or feet
☐ Taking RX heart medication (please list below)
☐ Anemia
☐ Sickle Cell Disease
☐ History of DVT
☐ Varicosities
☐ Other (please list below)

Details for any boxes checked above or other non listed problem:_____

_____

**Neurological**

☐ Seizures
☐ Tremors
☐ Twitches
☐ Lack of coordination
☐ Fainting
☐ Parkinson's Disease
☐ Areas of numbness (list below)
☐ Neuropathy
☐ Poor memory
☐ Loss of balance
☐ Other (list below)

Details for any boxes checked above or other non listed problem:_____

_____

_____

**GI**

☐ Abdominal pain/cramping
☐ Pain after eating
☐ Pain when hungry
☐ Bloating
☐ Excessive gas
☐ Acid reflux
☐ Nausea
☐ Vomiting
☐ Peptic Ulcer
☐ Fatty Liver
☐ Hepatitis
☐ Gall bladder problems
☐ Difficulty digesting fats
☐ Change in appetite
☐ Other

Details for any boxes checked above or other non listed problem:_____

_____

_____

**Bowel Movements**

☐ Well formed, daily
☐ Constipation
☐ Diarrhea
☐ Hard
☐ Dry
☐ Watery
☐ Loose
☐ Soft
☐ With mucous
☐ With blood
☐ Incomplete feeling
☐ Foul smelling
☐ Hemorrhoids
☐ Other (please note below)

Details for any boxes checked above or other non listed problem:_____

_____

_____

**Gynecological**

☐ N/A
☐ PMS symptoms (list below)
☐ PMDD symptoms (list below)
☐ Cycle every 20-22 days
☐ Cycle every 23-25 days
☐ Cycle every 26-27 days
☐ Cycle every 28-30 days
☐ Cycle every 30-39 days
☐ Cycle more than 40 days
☐ Irregular cycle
☐ Amenorrhea
☐ Dysmenorrhea - moderate pain
☐ Dysmenorrhea - heavy pain
☐ Spotting before menses
☐ Spotting after menses
☐ Spotting between menses
☐ Light/scanty menses
☐ Moderate/normal menses
☐ Heavy menses
☐ Menstrual discharge contains small clots
☐ Menstrual discharge contains large clots
☐ Cysts/Breast Lumps
☐ Hysterectomy - total
☐ Hysterectomy - partial (please give details below)
☐ Oophorectomy
☐ Inability to conceive
☐ Frequent miscarriages
☐ History of failed IUI
☐ History of failed IVF
☐ C-section
☐ Full term delivery
☐ Pain with intercourse
____Pregnancies
____Deliveries
____Abortions
____Miscarriages
☐ Menopause
☐ Hormone Therapy
☐ Birth Control
☐ Other (please provide details below)

Details for any boxes checked above or other non listed problem:_____

_____

_____

**Urological**

☐ Urgency to urinate
☐ Frequent Urination
☐ Urinary incontinence
☐ Painful urination
☐ Incomplete urination
☐ Pale urination
☐ Dark urination
☐ Copious urination
☐ Scanty urination
☐ Dribbling urination
☐ Blood in urine
☐ Decrease urine flow/pressure
☐ Kidney stones
☐ Kidney disease
☐ Enlarged Prostate
☐ Erectile dysfunction
☐ Hormonal therapy (men)
☐ Other (please describe below)

Details for any boxes checked above or other non listed problem:_____

_____

_____

**Endocrine**

☐ Thyroid disease - Hypo ☐ Diabetes ☐ PCOS
☐ Thyroid disease - Hyper ☐ Pre-diabetes ☐ Other
Details for any boxes checked above or other non listed problem:_____

_____

_____

**Sleep**

☐ No Problems
☐ Difficulty falling asleep
☐ Difficulty staying asleep
☐ Difficulty falling and staying asleep
☐ Wakes early
☐ Pain interfering with sleep
☐ Dream-disturbed sleep
☐ Restlessness
☐ Night sweating
☐ Snoring
☐ Wakes frequently because of partner/baby/animals or other outside influence
☐ Works night shift
☐ Disturbing dreams
☐ Waking to urinate 1-2 times per night
☐ Waking to urinate 3-4 times per night
☐ Waking to urinate more that 4 times per night
☐ Sleeps less than 4 hours per night
☐ Sleeps 4-6 hours per night
☐ Sleeps 6-8 hours per night
☐ Sleeps 8-10 hours per night

Details for any boxes checked above or other non listed problem:_____

_____

_____

**Perspiration Hot/Cold**

☐ Normal perspiration ☐ Excessive perspiration ☐ Usually feels cold
☐ Does not perspire easily ☐ Hot flashes ☐ Usually feels hot
☐ Perspires easily upon exertion ☐ Night sweating
☐ Profuse night sweating

Details for any boxes checked above or other non listed problem:_____

_____

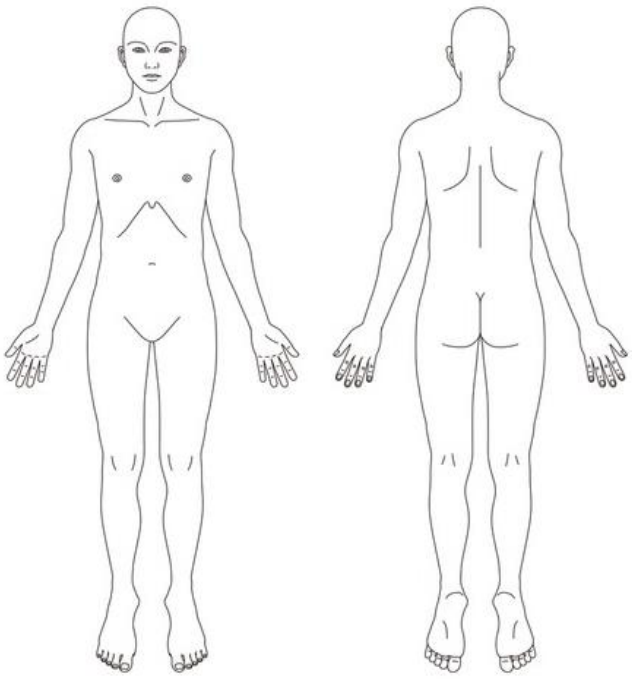
_____

**Musculoskeletal and pain**

☐ Joint pain - multiple sites
☐ Knee pain
☐ Neck pain
☐ Back pain
☐ Hand pain
☐ Foot Pain
☐ Wrist pain
☐ Carpal tunnel syndrome
☐ Elbow pain
☐ Hip pain
☐ Arthritis
☐ Osteopenia
☐ Osteoporosis

Please note primary area of pain:_____

_____



Please check any applicable boxes describing the nature of your primary pain

☐ N/A
☐ Constant
☐ Intermittent
☐ Occasional
☐ Sharp
☐ Stabbing
☐ Achy
☐ Fixed
☐ Spasm
☐ Worse standing
☐ Worse laying down
☐ Worse walking
☐ Hot
☐ Cold
☐ Feels heavy
☐ Worse during day
☐ Worse at night
☐ Migrating pain
☐ Better with heat
☐ Better with cold
☐ Better with pressure
☐ Worse bending
☐ Worse driving
☐ Worse with stress
☐ Better sitting
☐ Better standing
☐ Better laying down
☐ Better if moving
☐ Better when walking
☐ Worse with pressure
☐ Worse sitting
☐ Worse lifting
☐ Worse if sedentary
☐ Worse stairs - up
☐ Worse stairs - down

Please indicate the severity of this pain at its worst (with 10 being worst)

0 1 2 3 4 5 6 7 8 9 10

Please indicate the severity of this pain at its best (with 0 being best)

0 1 2 3 4 5 6 7 8 9 10

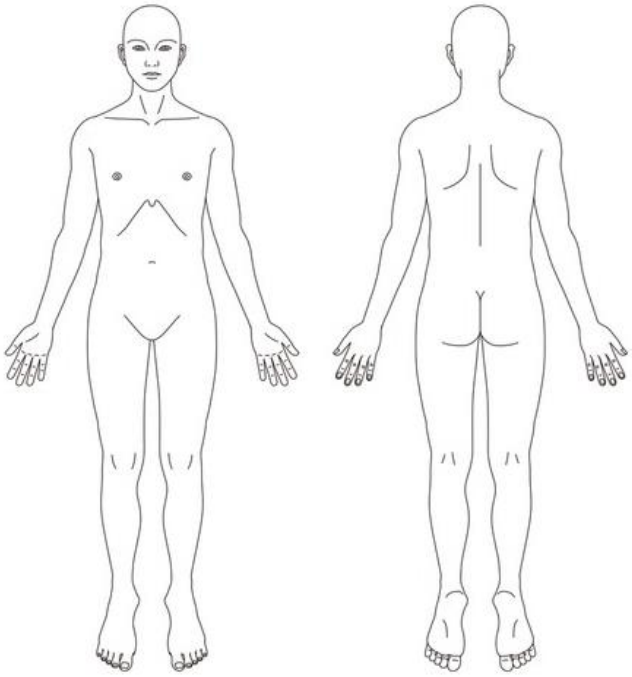
Please provide additional information about your pain. Please include how long you've had the pain and if you've had or are currently having treatment for it:_____

_____

_____

Please describe the area of any secondary pain:_____

_____



Please indicate the severity of this pain at its worst (with 10 being worst)

0 1 2 3 4 5 6 7 8 9 10

Please indicate the severity of this pain at its best (with 0 being best)

0 1 2 3 4 5 6 7 8 9 10

Please check any applicable boxes describing the nature of your secondary pain

☐ N/A
☐ Constant
☐ Intermittent
☐ Occasional
☐ Sharp
☐ Stabbing
☐ Achy
☐ Fixed
☐ Spasm
☐ Worse standing
☐ Worse laying down
☐ Worse walking
☐ Worse with stress
☐ Hot
☐ Cold
☐ Feels heavy
☐ Worse during day
☐ Worse at night
☐ Migrating pain
☐ Better with heat
☐ Better with cold
☐ Better with pressure
☐ Worse bending
☐ Worse driving
☐ Better sitting
☐ Better standing
☐ Better laying down
☐ Better if moving
☐ Better when walking
☐ Worse with pressure
☐ Worse sitting
☐ Worse lifting
☐ Worse if sedentary
☐ Worse stairs - up
☐ Worse stairs - down

Please provide additional information about your pain. Please include how long you've had the pain and if you've had or are currently having treatment for it:_____

_____

Please note any other areas of pain not covered above:_____

_____

**Psychological, Mood, and Energy**

☐ Brain fog
☐ Fatigue
☐ Always tired in the afternoon
☐ Always tired when waking
☐ Other mental or emotional concern (note below)
☐ Better in the morning
☐ Better in the evening
☐ Restless
☐ Phobia or fear
☐ Irritability
☐ Anxiety
☐ Depression
☐ In therapy
☐ Mood swings
☐ ADHD
☐ Bipolar disorder

Details for any boxes checked above or other non listed problem

**Diet/Lifestyle/Exercise**

☐ Vegetarian diet
☐ Vegan diet
☐ Pescatarian diet
☐ Gluten Free
☐ Paleo
☐ Other:_____

Food Allergies/sensitivities_____

Exercise - type and amount per week_____

Alcohol use_____Smoking_____

Recreational drug use_____

Meditative practice_____

Diet/Lifestyle/Exercise goals_____

Any other questions or concerns not covered above_____

_____