Acupuncture for Everyone ~ Health History Questionnaire

Name	DOB	Age
Address	City	State/Zip

Home Phone	Work Phone	Email
Height	Weight	Occupation

How did you hear about us?	Have you had acupuncture before? Y / N
Main Health Issues: Please write in your top 3 health issues/concerns in order of importance. Please rate severity on a scale of 1-10, 1 being no symptoms, 10 cannot imagine it being worse.	2. When did this start? Severity Scale 1__________5__________10
1. When did this start? Severity Scale 1__________5__________10	3. When did this start? Severity Scale 1___________5__________10

HEALTH HISTORY

Below is a list of various conditions. Circle 'you' if you have had this condition, now or in the past including the year it started. If there is a family history of the condition, circle 'family.'

Cancer you / family year: type:	Diabetes you / family year: type:	Hepatitis you / family year: type:	High Blood Pressure you / family year:
Heart Disease you / family year:	Stroke you / family year:	Seizures you / family year:	Thyroid Dis. you/family year:
Asthma you / family year:	Pacemaker you / family year:	Osteoporosis you / family year:	Herpes you / family year:
AIDS/HIV you / family year:	Other STD you / family year:	RheumaticFever you/fam year:	Alcoholism you / family year:
Allergies you / family year:	Mental Illness you / family year:	Kidney Dis. you / family year:	Anemia you / family year:

Habits Amount/week If you have quit, list the year	**Exercise** Do you exercise regularly? Y / N If so what and how often?	**Diet** Do you have a special diet, now or in the past? Please describe.	**Medication** Please note what medications, herbs or supplements you take regularly.	**Injuries/Surgeries** Please note what happened to what body area and when it occurred.
Coffee/tea _________ Soda ______________ Tobacco ___________ Alcohol ____________ Drugs _____________				

Check symptoms you have had in the past month.

Temperature:
- ❑ Cold hands or feet
- ❑ Chills
- ❑ Cold 'in the bones'
- ❑ Areas of numbness
- ❑ Hot hands, feet, chest
- ❑ Hot flashes (day/ afternoon/ night)
- ❑ Night sweats
- ❑ Excessive thirst
- ❑ Thirst for hot or cold drink
- ❑ Absence of thirst
- ❑ Unusual daytime sweats - area: ______________

Moisture:
- ❑ Dry skin
- ❑ Dry hair
- ❑ Dry eyes
- ❑ Dry brittle nails
- ❑ Dry mouth
- ❑ Dry lips
- ❑ Dry throat
- ❑ Dry nose
- ❑ Edema/swelling, area: ___________
- ❑ Rashes, area: ______________
- ❑ Itching, area: ______________
- ❑ Dandruff
- ❑ Oily skin
- ❑ Oily hair
- ❑ pimples

Digestion:
- ❑ Bowel movements ___x/every ____days
- ❑ Stools keep shape Y / N
- ❑ Gas
- ❑ Alternating diarrhea & constipation
- ❑ Indigestion
- ❑ Bloating
- ❑ Belching
- ❑ Poor appetite
- ❑ Heartburn
- ❑ Nausea/Vomiting
- ❑ Bad breath
- ❑ Excessive hunger
- ❑ Dry stools
- ❑ Stools difficult to pass
- ❑ Tired after BM
- ❑ Foul smelling stools

Energy:
- ❑ Sudden energy drop, time: _____
- ❑ Low energy after eating
- ❑ Fatigue
- ❑ Caffeine/stimulant dependency
- ❑ Wired/ungrounded feeling
- ❑ Body/limbs feel heavy
- ❑ Body/limbs feel weak
- ❑ Shortness of breath
- ❑ Heart palpitations
- ❑ Blood Pressure High Low
- ❑ Bleed or bruise easily
- ❑ Hard to concentrate
- ❑ Dizzy/lightheaded
- ❑ Headaches: # per week _____

Sleep:
- ❑ # of hours/night: ___
- ❑ Difficulty falling asleep
- ❑ Waking ___x/night
- ❑ Wake to urinate ___x/night
- ❑ Disturbing dreams
- ❑ Restless sleep
- ❑ Not rested on waking

Emotions:
- ❑ Anger
- ❑ Irritable
- ❑ Anxious
- ❑ Worry
- ❑ Obsessive thinking
- ❑ Sad
- ❑ Grieving
- ❑ Depressed
- ❑ Joyful
- ❑ Fearful
- ❑ Timid/shy
- ❑ Indecisive

Ears/Eyes/Nose/Throat:
- ❑ Poor vision
- ❑ Night blindness
- ❑ Red eyes
- ❑ Itchy eyes
- ❑ Spots in front of eyes
- ❑ Phlegm, color: ________
- ❑ Poor hearing
- ❑ Ringing in ears
- ❑ Excess ear wax
- ❑ Sore throat
- ❑ Dental problems
- ❑ Mouth sores
- ❑ Cough

Genito/Urinary:
- ❑ Excess urination
- ❑ Decreased flow
- ❑ Dribbling
- ❑ Difficulty start/stop flow
- ❑ Incontinence
- ❑ Kidney stones
- ❑ Urinary urgency
- ❑ Urinary frequency
- ❑ Pain on urination
- ❑ Burning sensation
- ❑ Cloudy urine
- ❑ Blood in urine
- ❑ Sores on genitals
- ❑ Prostate disease
- ❑ Genital pain
- ❑ Hernia
- ❑ Vasectomy

Reproductive Health:
- ❑ Change in sexual drive
- ❑ Erectile dysfunction
- ❑ Age at first menses ____
- ❑ Length of menstrual cycle _______
- ❑ Last Menses start date: _________
- ❑ #pregnancies ___ #live births ___
- ❑ #abortions/miscarriages _____
- ❑ Periods: heavy moderate or light
- ❑ Painful periods
- ❑ Irregular periods
- ❑ PMS/Changes in mood
- ❑ Cramps (before/first day/during)
- ❑ Clots
- ❑ Breast tenderness
- ❑ Digestive changes with menses
- ❑ Midcycle spotting
- ❑ Midcycle pain
- ❑ Yeast infections
- ❑ Menopause, age _______