***Health History Questionnaire for Patients***

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| --- |
| Welcome to our clinic! Please help us provide you with a complete evaluation by taking the time to fill out this questionnaire carefully. All of your answers will be held confidential, unless required by law to release. If you have any questions, please ask. Thank you! |

Last Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_First Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_MI\_\_\_\_

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State\_\_\_Zip\_\_\_\_\_\_

Cell\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Home\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Work\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Which contact do you prefer to get appt. reminders and messages on? Cell Email Home Work (circle)

Date of Birth\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_\_Height\_\_\_\_\_\_\_Weight\_\_\_\_\_\_\_Age\_\_\_\_\_\_\_Sex M F

Primary care physician\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Approx. date of last visit\_\_\_\_\_\_\_\_\_\_\_\_\_

Whom may we thank for your referral?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you tried acupuncture or Chinese medicine before?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |
| --- |
| **Emergency Contact Information:**  First Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Last Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Phone: Cell\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Home\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Work\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Relationship\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

List your health complaints in order of priority: How long since it started:

1.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you been given a diagnosis for any of the above problems by your physician and if so what are they?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What kinds of treatment or therapy have you tried?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

To what extent does problem # 1 affect your daily activities (work, sleep, eating, etc.)?\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What makes problem #1 feel better (heat, ice, rest, exercise, etc.)?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What makes it worse?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**MEDICATIONS SUPPLEMENTS**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**MEDICAL HISTORY**

\_\_Allergies \_\_Rheumatic fever \_\_Epilepsy \_\_Diabetes

\_\_Hepatitis \_\_High blood pressure \_\_Thyroid disease \_\_Seizures

\_\_Cancer \_\_Venereal disease \_\_HIV positive \_\_Miscarriage

\_\_Broken bones \_\_Head injury \_\_Fainting \_\_Hospitalization

\_\_Surgeries \_\_Metal pins/plates \_\_Pacemaker or other electrical device

**FAMILY MEDICAL HISTORY**

\_\_Cancer \_\_Heart disease \_\_Stroke \_\_Asthma

\_\_Diabetes \_\_Seizures \_\_Alcoholism \_\_Abuse

\_\_Drug abuse \_\_High blood pressure \_\_Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**CURRENT AND FORMER SYMPTOMS**

Please X for symptoms you experience now (within the last week or so)

Underline those symptoms you have had in the past (a month to a year ago)

\_\_Allergies \_\_Sciatica \_\_Mouth/tongue sores

\_\_Arm/shoulder pain \_\_Low back pain \_\_Palpitations

\_\_Asthma \_\_Sore throat in AM \_\_Poor circulation

\_\_Constipation \_\_Ears ring (low pitch) \_\_Restlessness

\_\_Cough/sneeze/phlegm \_\_Urination problems \_\_Upper back pain

\_\_Eczema/Psoriasis/Rash \_\_Low will power \_\_Abdominal pain

\_\_Elbow pain \_\_Anger/irritability \_\_Aching/heavy limbs

\_\_Fatigue/tired \_\_Blurry vision/spots \_\_Belching

\_\_Flatulence/gas \_\_Brittle/coarse nails/hair \_\_Indigestion/acid reflux

\_\_Frequent colds \_\_Distention/bloating \_\_Difficulty focusing

\_\_Frontal/sinus headache \_\_Eye/vision trouble \_\_Hiccups

\_\_Grief/sadness \_\_Headaches \_\_Loose stools

\_\_Mucus \_\_Hemorrhoids \_\_Muscle weakness

\_\_Nasal obstruction/discharge \_\_Irritable bowel \_\_Worry/overthinking

\_\_Sinusitis \_\_Migraines \_\_Fainting

\_\_Sense of smell issues \_\_Nausea/vomiting \_\_DIzziness

\_\_Sweating issues \_\_Stiff neck \_\_Loss of sleep

\_\_Weak voice \_\_Stiff shoulders \_\_Nervousness

\_\_Wheezing/SOB \_\_Tension/cramps \_\_Weight gain/loss

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\_\_Back/Knees weak/pain \_\_Ears ring (high pitch) \_\_Confusion

\_\_Bladder infect./control \_\_Anemia \_\_Autoimmune disorder

\_\_Brittle bones \_\_Anxiety/dread \_\_Difficulty breathing

\_\_Cold/Hot \_\_Dream disturbed sleep \_\_Slow/Rapid/Irreg. heart

\_\_Dark/puffy around eyes \_\_Hearing problems \_\_Low blood pressure

\_\_Depression/fear \_\_Heart problems \_\_Swelling of ankles

\_\_Edema/water retention \_\_Hot flashes \_\_Varicose veins

\_\_Low sexual energy \_\_Hot painful joints \_\_Foot problems

\_\_Loss/thinning hair \_\_Insomnia \_\_Poor memory

\_\_Premature grey \_\_Lack of joy/humor \_\_Hernia

\_\_Kidney stones or infection \_\_Poor appetite \_\_Excessive hunger

\_\_Diarrhea \_\_Gallbladder problems \_\_Hepatitis

**MALE:**

\_\_Pain associated with genitals \_\_Premature ejaculation \_\_Impotence

\_\_Discharges

**FEMALE:**

\_\_Painful menstrual periods \_\_Excessive flow \_\_Irregular cycle

\_\_Cramps or backache \_\_Miscarriage \_\_Vaginal discharge

\_\_Vaginal pain \_\_Breast pain \_\_Lumps in breast

\_\_Endometriosis \_\_Ovarian cysts \_\_Pregnancy complications

\_\_Hot flashes \_\_Menopausal symptoms Number of pregnancies\_\_\_\_

Number of live births\_\_\_ Date of last Pap\_\_\_\_\_\_\_.......Was it normal Y N

Date of last mammogram\_\_\_\_\_\_\_\_ Currently using birth control Y N...Type\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Are you pregnant Y N?** Trying to get pregnant Y N

**LIFESTYLE**

Do you smoke Y N

Have history of smoking Y N

Do you follow a regular exercise program Y N

If yes please describe\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What activities/hobbies do you have:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How much alcohol do you consume a week\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_caffine drinks per day\_\_\_\_

How many hours do you watch TV per day\_\_\_

Do you have one person in your life with whom you may discuss **anything**? Y N

Do you drink at least 32oz of water a day Y N

What concerns you most about your health?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Any other information about your health that you feel is important for me to know about:\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**AUTHORIZATION**

I certify that I have read and understood the above information to the best of my knowledge. I Understand that by withholding information or giving false information may be dangerous to my health. I authorize Acupuncture in Vancouver to release any information to my insurance company and/or attorney which may be necessary to process my claim. I authorize payment of my benefits directly to Acupuncture in Vancouver for services rendered. I understand that I am personally responsible for any non-covered benefits and services and agree to pay them in a timely manner.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_

Patient signature

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