Acupuncture Treatment Health Questionnaire

Name _____ _____Date: _____

Address: _____ City, State: _____

Zip: _____ Date of Birth _____/_____/_____ Age _____

Phone - Home _____ Cell _____

Email address _____ Height _____ Weight _____

Employer _____ Work Phone: _____

Occupation _____ Referred by _____

How did you hear about us? _____ Marital Status _____

Emergency contact _____ Emergency phone _____

Main Concern Presently? _____

How Long Have you been experiencing this issue(s)? _____

Does this problem interfere with daily activities? Please explain. _____

Have you been given a diagnosis for this problem?_____

Have you had any imaging done (MRI, X-Ray, Ultrasound, etc) _____

Additional Concerns you would like to be treated & addressed? _____

Surgeries: (Please include date) _____

_____

Significant Trauma: (Describe accidents, falls…with dates, treatment, & results) _____

_____

Medicines taken within the last two months (including OTC vitamins, drugs, herbs…) _____

_____

Allergies: (Causes, symptoms, discomforts) _____

MUSCULOSKELETAL:

( ) Neck pain ( ) Back Pain ( ) Shoulder Pain ( ) Knee Pain ( ) Hip

( ) Hand/Wrist Pain ( ) Foot/Ankle Pain ( ) Other Muscle Pain _____ ( ) Muscle Weaknes

Other Joint or Bone Problems _____

PAIN LEVEL: indicate level of pain today (scale 0 -> 10) _____ (0=🙂, 5=☹️, 10=😫)

( ) Sharp Pain ( ) Dull Pain ( ) Constant Pain ( ) Intermittent Pain

W/Pressure, Pain is ( ) worse, or ( ) better ( ) Relieved by Rest ( ) Better w/Movement or Activity

PERSONAL HISTORY: (check all that apply, note history & treatment)

( ) Cancer ( ) Diabetes ( ) Hepatitis
( ) Heart Disease ( ) Sexually Transmitted Disease ( ) High Blood Pressure
( ) Thyroid Disease ( ) Seizures ( ) Other

How much caffeine do you drink a day? _____ How many cigarettes do you smoke a day? _____
How much alcohol do you drink during a typical week? _____

FAMILY MEDICAL HISTORY (Please identify the family member's relation to you)

( ) Cancer ( ) Diabetes ( ) Allergies
( ) Heart Disease ( ) Asthma ( ) High Blood Pressure
( ) Stroke ( ) Seizures ( ) Other

Please explain if you have had any of the following within the last 3 months:

GENERAL:

( ) Poor Appetite ( ) Strong Thirst ( ) Fatigue
( ) Changes in Appetite ( ) Fevers ( ) Poor Sleep / Trouble Sleeping
( ) Weight Loss ( ) Chills ( ) Poor Balance
( ) Weight Gain ( ) Sweating Easily ( ) Localized Weakness
( ) Peculiar Tastes or Smells ( ) Night Sweats ( ) Sudden Energy Drop
( ) Cravings (circle all that apply) ( ) Bleed or Bruise easily Time of Day _____
sugar salt sour spicy ( ) Tremors

SKIN & HAIR:

( ) Rashes ( ) Ulcerations ( ) Hives
( ) Itches ( ) Eczema ( ) Pimples
( ) Dandruff ( ) Hair loss ( ) Recent Moles
( ) Change in hair or skin texture Other _____

CARDIOVASCULAR:

( ) High Blood Pressure ( ) Low Blood Pressure ( ) Chest Pain
( ) Irregular heartbeat ( ) Dizziness ( ) Fainting
( ) Cold Hands or Feet ( ) Swelling of Hands ( ) Swelling in Feet
( ) Blood Clots ( ) Phlebitis ( ) Difficulty in Breathing

Other Heart or Circulatory Problems _____ ( )PaceMaker

RESPIRATORY:

( ) Cough ( ) Coughing Up Blood ( ) Asthma
( ) Bronchitis ( ) Pneumonia ( ) Pain with Deep Breaths
( )Difficulty Breathing When Lying Down ( ) Thick Phlegm Expectorated Color: _____
( ) Dry Cough ( ) Post Nasal Drip ( ) Thin Watery Phlegm Expectorated

Other Lung Problems _____

GASTROINTESTINAL:

( ) Nausea ( ) Vomiting ( ) Diarrhea
( ) Constipation ( ) Gas ( ) Belching
( ) Black Stools ( ) Blood in Stools ( ) Indigestion/Reflux/GERD
( ) Bad Breath ( ) Rectal Pain ( ) Hemorrhoids
( ) Abdominal Pain or Cramps Other Stomach or Intestinal Problems _____

HEAD, EYES, EARS, NOSE & THROAT:

( ) Recurrent Sore Throats ( ) Ear Aches ( ) Poor Vision
( ) Sores on Lips or Tongue ( ) Poor Hearing ( ) Cataracts
( ) Sinus Problems ( ) Teeth Problems ( ) Ringing in Ears
( ) Nose Bleeds ( ) Grinding Teeth ( ) Blurry Vision
( ) Facial Pain ( ) Clicking Jaw ( ) Eye Strain
( ) Concussion(s) ( ) Night Blindness ( ) Eye Pain
( ) Dizziness ( ) Glasses ( ) Spots in Front of Eyes
( ) Migraines ( ) Color Blindness

Headaches - where & when _____

Other head or neck problems _____

GENITO-URINARY:

( ) Pain on Urination ( ) Frequent Urination ( ) Blood in urine
( ) Urgent Urination ( ) Unable to Hold Urine ( ) Sores on Genitals
( ) Decrease in Urine Flow ( ) Kidney Stones ( ) Impotence
( ) Waking at night to Void - How Often _____ Color of Urine _____

REPRODUCTIVE & GYNECOLOGIC:

Births _____ Date of Last menses _____ ( ) Irregular or NO Periods
Miscarriages _____ Length of Menses _____ Last PAP _____
Abortions _____ Days Between Menses _____ ( ) Breast Lumps or Pain
Clots: ( ) Dark ( ) Red Flow: ( ) Heavy ( ) Light ( ) Chronic Yeast/Bacterial Infecti

Birth Control Type & Length of Use _____

Pain with Cycle: ( ) Beginning ( ) Ending ( ) Ovulation PMS: ( ) Psyche ( ) Body

Vaginal Discharge/Leukorrhea - please describe _____

NEUROPSYCHOLOGICAL:

( ) Seizures ( ) Dizziness ( ) Loss of Balance
( ) Areas of Numbness ( ) Lack of Coordination ( ) Poor memory
( ) Concussion ( ) Depression ( ) Anxiety
( ) Bad Temper/ Irritable ( ) Low Tolerance for Stress

Have you been treated for emotional problems? _____ Have you considered or attempted suicide?_____