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:_____

Date of Birth: ___/___/_____

Guardian (if under 18):_____

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

Social Security Number:_____

Occupation:_____ Employer:_____

Employer Address:_____

_____

Does anything limit you from care? [ ]Yes [ ]No If yes, explain:_____

_____

How did you hear about our office?_____

Other physicians/therapists seen for this condition:_____

Medications (if any):_____

Prescribed by:_____

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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 dates below):

Physical: _____ Cholesterol: _____ Prostate: _____

Blood (which?): _____ HIV/STD: _____ Pap smear: _____

Mammography: _____ Other: _____

Tests Result(s) and Date(s): _____

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	

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:_____	☐	☐	

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Where are you in the birth order? ☐ First ☐ Last ☐Middle ☐ Only Child

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):

In 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
☐ Exercise	☐ Other_____	

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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 flashes
☐ Night sweats
☐ Heat in the hands, feet and chest
☐ Hot flashes at 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 (# 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 (# 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 stool
☐ 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

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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
☐ Consultations
☐ 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
☐ Gallstones (history or current)
☐ Sexually transmitted disease (Which? _____ _____)

Libido:
☐ Normal
☐ High
☐ Low

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 infection
☐ 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 order
☐ Burning
☐ Painful
☐ Discharge
☐ Difficult
☐ Painful
☐ Urgent
☐ Frequent

Other symptoms:_____

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WOMEN ONLY:

Regular menstrual cycle? ☐ Yes ☐ No
Number of children:_____
Age of first menstruation:_____
Average number of days of flow:_____
Average number of days of entire cycle:_____
Pregnant? ☐ Yes ☐ No
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:_____

Please fill in the following menstrual chart (put in a number and what color it is):

	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:_____	☐	☐	☐	☐

Other comments:_____

_____

Patient Signature:_____

Acupuncturist Signature:_____

Date:_____

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