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, and Postal Code:
____

Home Phone: ______________________ Work Phone:______________________

Cell Phone:______________________ Circle the best phone to reach you.

Age: ______ Date of Birth: ____/____/____ Place of Birth:_________________________

Guardian (if under 18):
____

Gender:☐M☐F Height:____'____" Weight:______lbs.

Occupation:________________________________Employer:__________________________

How did you hear about our office? ____

Major Complaint(s), in order of significance to you:

1.____________________________________ 4. _________________________

2. ____________________________________ 5.__________________________

3. ____________________________________ Additional:______________________________

____

How do these conditions impair your daily activities?________________________________

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II. Patient Medical History

How was your childhood health? ____

Hospital visits____:
Recent tests: (please indicate test results and date below)

☐Physical	☐Cholesterol	☐Prostate	☐Blood (which?)
☐HIV/STD	☐Pap smear	☐Mammography	☐Other:

Test Results and Date:
____

Check any you have had in the past:

☐Diabetes	☐Rheumatic Fever	☐Thyroid disorder	☐Emphysema
☐Heart Disease	☐Bleeding tendency	☐Nervous disorder	☐Mononucleosis
☐Asthma	☐Multiple Sclerosis	☐Pneumonia	☐High blood pressure
☐Jaundice	☐Gonorrhea	☐Measles	☐HIV
☐Syphilis	☐Allergies	☐CVA (stroke)	☐Pneumonia
☐Meningitis	☐Glaucoma	☐Vein condition	☐Tuberculosis
☐Epilepsy	☐Mumps	☐Chicken pox	☐Polio
☐Paralysis	☐Hepatitis	☐Migraines	☐Cancer
☐Other lung illnesses	☐other liver illnesses	☐other heart illnesses	☐other kidney illnesses

☐Other: ___________

Surgeries:____

Immunizations:____

III.Patient Profile

Please clearly mark any areas of pain and any scars (please indicate which of the areas are scars):
Is 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 ☐Other:___________________________

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:Please check the following that currently pertain to you :

(Overall Temperature (Kidney function):

☐Cold hands ☐Cold feet ☐Sweaty hands
☐Hot body temperature (sensation) ☐Afternoon flushes ☐Cold fingers
☐Heat in the hands, feet, and chest ☐Cold toes ☐Sweaty feet
☐Cold body temperature (sensation) ☐Night sweats ☐Perspire easily
☐Hot flashes any time of the day ☐Thirsty ☐Lack of perspiration
☐Take water to bed

Overall energy (Lung, Kidney function):

☐Easily catch colds ☐Feel worse after exercise ☐Shortness of breath
☐General weakness ☐Low energy ☐Difficulty keeping eyes open in the daytime

Overall blood (Liver, Spleen, Heart function):

☐Dizziness ☐See floating black spots

Heart function:

☐Palpitations ☐Sores on the tip of the tongue ☐Mental confusion
☐Frequent dreams ☐Anxiety ☐Restlessness
☐Chest pain traveling to shoulder ☐Wake unrefreshed
☐Drink coffee (# of cups per week: _______)

Lung function:

☐Nasal Discharge (Color: _________) ☐Nose Bleeds ☐Dry mouth
☐Allergies (To what? _______________) ☐Sneezing ☐Overall achy feeling
☐Stiff shoulders ☐Sadness ☐Cough
☐Sinus Congestion ☐Dry throat ☐Dry Skin
☐Alternating fever and chills ☐Dry Nose
☐Headache (Location: _______________) ☐Stiff neck ☐Sore throat
☐Smoke cigarettes (# per day: _______) ☐Melancholy ☐Difficulty breathing

Spleen function:

☐Low appetite ☐Abrupt weight loss ☐Abdominal gas
☐Fatigue after eating ☐Easily bruised ☐Pensive
☐Worry ☐Abrupt weight gain ☐Abdominal bloating
☐Gurgling noise in the stomach ☐Hemorrhoids ☐Over-thinking
☐Prolapsed organs (previously diagnosed, which organ? ________________)

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Spleen, Stomach, Large Intestine, Small Intestine function:
☐Loose Stool ☐Incomplete ☐Blood in stools
☐Undigested food in stools ☐Constipated ☐Diarrhea ☐Mucous in stools

Dampness trapped in the body:
☐General sensation of heaviness in the body
☐Mental sluggishness ☐Swollen hands ☐Swollen joints
☐Nausea ☐Snoring ☐Mental heaviness
☐Mental fogginess ☐Swollen feet ☐Chest congestion

Stomach function:
☐Burning sensation after eating ☐Bad breath ☐Bleeding, swollen or painful gums
☐Acid regurgitation ☐Belching ☐Stomach pain
☐Large appetite ☐Heartburn ☐Ulcer (diagnosed)
☐Hiccoughs ☐Vomiting ☐Mouth (canker) sores

Liver, Gall Bladder function:
☐Tight sensation in the chest ☐Anger easily ☐Depression
☐Frequently unable to adapt to stress (What causes the stress? ___________________)
☐Skin rashes ☐Tingling sensation ☐Muscle spasms
☐Muscle cramping ☐Convulsions ☐Neck tension
☐Shoulder tension ☐Limited Range-of-Motion, Shoulder
☐Recreational drugs (Which? ___________________, How much per week? ________)
☐Alcohol drinking (How much per week? ________) ☐Chest pain
☐High-pitched ringing in the ears ☐Alternating diarrhea and constipation
☐Sexually transmitted disease (Which? ______________) ☐Gall stones
☐Bitter taste in the mouth ☐Frustration ☐Irritability
☐Headache at the top of the head ☐Numbness ☐Muscle twitching
☐Seizures ☐Lump in the throat ☐Limited Range-of-Motion

Eyes (Liver function):
☐Itchy ☐Hot ☐Watery ☐Blurry vision ☐Near-sighted
☐Bloodshot ☐Dry ☐Gritty ☐Decreased night vision ☐Far-sighted

Urination :
☐Normal color ☐Scanty ☐Burning ☐Frequent ☐Dark yellow
☐Profuse ☐Painfu ☐Clear ☐Reddish ☐Cloudy
☐Strong odor ☐Discharge ☐Difficult ☐Urgent

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Kidney, Urinary Bladder function:
☐Frequent cavities ☐Sore knees ☐Cold sensation in the knees ☐Memory problems
☐Low-pitched ringing in the ears ☐Bladder infections ☐Weak knees
☐Lack of bladder control ☐Easily startled ☐Kidney stones
☐Easily broken bones ☐Low back pain ☐Fear
☐Excessive hair loss ☐Kidney stones
☐Wake during the night 2x or more to urinate

Libido: ☐Normal ☐High ☐Low

***Women only*:**
Pregnant?☐Y☐N Regular menstrual cycle?☐Y☐N Date of most recent cycle_______
Number of children:_____ Age of first menstruation:_____
Average number of days of flow:_____ ☐Vaginal discharge
Number of pregnancies:_____ Age of menopause (if applicable):_____
Average number of days of entire cycle:_____ ☐Bleeding between periods

Do you experience any of the following pre-menstrual syndromes?
☐nausea ☐food cravings ☐depression ☐dull pain, where?_____________

Please fill in the following menstrual chart:

	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							

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Men only:

☐Swollen testes ☐Testicular pain
☐Feeling of coldness or numbness in external genitalia

All please fill out:

Other Comments:
____

____

____

____

____

Patient Signature:

____