



HEALTH HISTORY QUESTIONNAIRE

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, Postal Code: _____

Home Phone: _____ Cell Phone: _____ Fax: _____

Email Address: _____

Is it ok to contact you at any of the above number(s) for appt. reminders or follow up calls? Yes ___ No ___

Yes, you may contact me, but only at the following number(s): _____

Marital Status: Married ___ Single ___ Divorced ___ Widowed ___ Number of Children _____

Age: _____ Date of Birth: _____ Place of Birth: _____

Guardian (if under 18): _____

Gender: Male ___ Female ___ Height _____ Weight _____

Occupation: _____ Employer: _____

How did you hear about our office? _____

Have you received acupuncture therapy before? Yes ___ No ___

When? _____ With Whom? _____

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

1. _____ 4. _____

2. _____ 5. _____

3. _____ Additional: _____

How do these conditions impair your daily activities?

II. Patient Medical History

How was your childhood health? _____

(All) Hospital Visits/Stays: _____

Recent tests: (please indicate test results and date)

	Result	Date		Result	Date
<input type="checkbox"/>	Physical	_____	<input type="checkbox"/>	Cholesterol	_____
<input type="checkbox"/>	Prostate	_____	<input type="checkbox"/>	Blood (which?)	_____
<input type="checkbox"/>	HIV/STD	_____	<input type="checkbox"/>	Pap Smear	_____
<input type="checkbox"/>	Mammography	_____	<input type="checkbox"/>	Other:	_____

Check any you have had in the past:

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

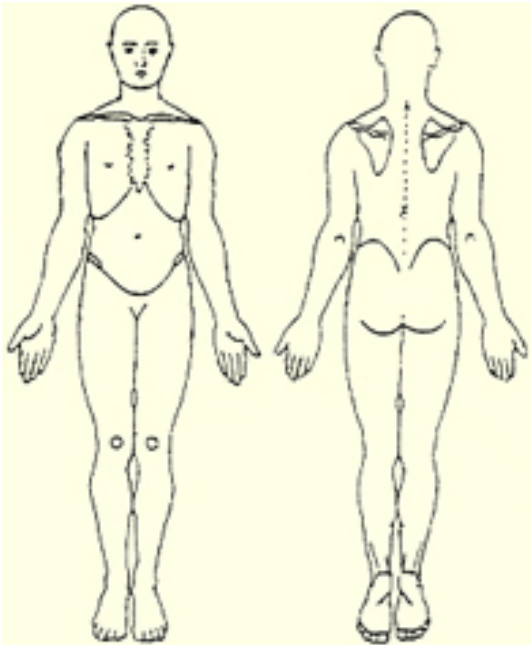
What are the other(s): _____

Immunizations: _____

Surgeries: _____

III. Patient Profile

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



Is the pain:

<input type="checkbox"/>	Sharp	<input type="checkbox"/>	Burning	<input type="checkbox"/>	Aching
<input type="checkbox"/>	Moving	<input type="checkbox"/>	Cramping	<input type="checkbox"/>	Fixed
<input type="checkbox"/>	Dull	Other: _____			

Do the following lessen the pain:

<input type="checkbox"/>	Heat	<input type="checkbox"/>	Cold	<input type="checkbox"/>	Exercise
<input type="checkbox"/>	Pressure	Other: _____			

Do the following worsen the pain:

<input type="checkbox"/>	Heat	<input type="checkbox"/>	Cold	<input type="checkbox"/>	Exercise
<input type="checkbox"/>	Pressure	Other: _____			

Please check the following symptoms that currently pertain to you:

Overall Temperature (Kidney function):

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

Overall energy (Lung, Kidney function):

<input type="checkbox"/>	Difficulty keeping eyes open in the daytime	<input type="checkbox"/>	General weakness
<input type="checkbox"/>	Easily catch colds	<input type="checkbox"/>	Low energy
<input type="checkbox"/>	Feel worse after exercise	<input type="checkbox"/>	Shortness of breath

Overall blood (Liver, Spleen, Heart function):

<input type="checkbox"/>	Dizziness	<input type="checkbox"/>	See floating black spots
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Heart function:

<input type="checkbox"/>	Anxiety	<input type="checkbox"/>	Mental confusion	<input type="checkbox"/>	Restlessness	<input type="checkbox"/>	Sores on the tip of the tongue
<input type="checkbox"/>	Palpitations	<input type="checkbox"/>	Frequent dreams	<input type="checkbox"/>	Wake unrefreshed	<input type="checkbox"/>	Chest pain traveling to shoulder

Lung function:

<input type="checkbox"/>	Alternating fever and chills	<input type="checkbox"/>	Dry Nose	<input type="checkbox"/>	Sinus Congestion
<input type="checkbox"/>	Cough	<input type="checkbox"/>	Dry Skin	<input type="checkbox"/>	Sneezing
<input type="checkbox"/>	Difficulty breathing	<input type="checkbox"/>	Melancholy	<input type="checkbox"/>	Stiff neck
<input type="checkbox"/>	Dry mouth	<input type="checkbox"/>	Nose Bleeds	<input type="checkbox"/>	Stiff shoulders
<input type="checkbox"/>	Dry throat	<input type="checkbox"/>	Sadness	<input type="checkbox"/>	Sore throat
<input type="checkbox"/>	Allergies - To What? _____				
<input type="checkbox"/>	Headache - Location: _____				
<input type="checkbox"/>	Nasal Discharge - Color: _____				
<input type="checkbox"/>	Smoke cigarettes - Number per day: _____				

Spleen function:

<input type="checkbox"/>	Abdominal bloating	<input type="checkbox"/>	Easily bruised	<input type="checkbox"/>	Low appetite
<input type="checkbox"/>	Abdominal gas	<input type="checkbox"/>	Fatigue after eating	<input type="checkbox"/>	Pensive
<input type="checkbox"/>	Abrupt weight gain	<input type="checkbox"/>	Gurgling noise in the stomach	<input type="checkbox"/>	Over-thinking
<input type="checkbox"/>	Abrupt weight loss	<input type="checkbox"/>	Hemorrhoids	<input type="checkbox"/>	Worry
<input type="checkbox"/>	Prolapsed organs - previously diagnosed, which organ? _____				

Spleen, Stomach, Large Intestine, Small Intestine function:

<input type="checkbox"/>	Blood in stools	<input type="checkbox"/>	Incomplete Bowel Movements	<input type="checkbox"/>	Mucous in stools
<input type="checkbox"/>	Constipation	<input type="checkbox"/>	Loose Stools	<input type="checkbox"/>	Undigested food in stools
<input type="checkbox"/>	Diarrhea				

Dampness trapped in the body:

<input type="checkbox"/>	Chest congestion	<input type="checkbox"/>	Mental heaviness	<input type="checkbox"/>	Swollen feet	<input type="checkbox"/>	Swollen hands
<input type="checkbox"/>	General sensation of heaviness in the body	<input type="checkbox"/>	Mental sluggishness	<input type="checkbox"/>	Swollen joints	<input type="checkbox"/>	Snoring
<input type="checkbox"/>	Mental fogginess	<input type="checkbox"/>	Nausea				

Stomach function:

<input type="checkbox"/>	Acid regurgitation	<input type="checkbox"/>	Bleeding, swollen or painful gums	<input type="checkbox"/>	Hiccoughs	<input type="checkbox"/>	Stomach pain
<input type="checkbox"/>	Bad breath	<input type="checkbox"/>	Burning sensation after eating	<input type="checkbox"/>	Large appetite	<input type="checkbox"/>	Ulcer (diagnosed)
<input type="checkbox"/>	Belching	<input type="checkbox"/>	Heartburn	<input type="checkbox"/>	Mouth / canker sores	<input type="checkbox"/>	Vomiting

Liver, Gall Bladder function:

<input type="checkbox"/> Alternating diarrhea and constipation	<input type="checkbox"/> Frustration	<input type="checkbox"/> Muscle cramping	<input type="checkbox"/> Seizures
<input type="checkbox"/> Anger easily	<input type="checkbox"/> Gall stones (history or current)	<input type="checkbox"/> Muscle spasms	<input type="checkbox"/> Shoulder tension
<input type="checkbox"/> Bitter taste in the mouth	<input type="checkbox"/> Headache at the top of the head	<input type="checkbox"/> Muscle twitching	<input type="checkbox"/> Limited Range-of-Motion, Shoulder
<input type="checkbox"/> Chest pain	<input type="checkbox"/> High-pitched ringing in the ears	<input type="checkbox"/> Neck tension	<input type="checkbox"/> Skin rashes
<input type="checkbox"/> Convulsions	<input type="checkbox"/> Irritability	<input type="checkbox"/> Limited Range-of-Motion, Neck	<input type="checkbox"/> Tight sensation in chest
<input type="checkbox"/> Depression	<input type="checkbox"/> Lump in the throat	<input type="checkbox"/> Numbness	<input type="checkbox"/> Tingling sensation
<input type="checkbox"/> Frequently unable to adapt to stress			
<input type="checkbox"/> What causes the stress?	_____		
<input type="checkbox"/> Sexually transmitted disease. Which?	_____		

Eyes (Liver function):

<input type="checkbox"/> Bloodshot	<input type="checkbox"/> Dry	<input type="checkbox"/> Far-sighted	<input type="checkbox"/> Hot	<input type="checkbox"/> Near-sighted
<input type="checkbox"/> Blurry vision	<input type="checkbox"/> Decreased night vision	<input type="checkbox"/> Gritty	<input type="checkbox"/> Itchy	<input type="checkbox"/> Watery

Kidney, Urinary Bladder function:

<input type="checkbox"/> Cold sensation in the knees	<input type="checkbox"/> Fear	<input type="checkbox"/> Low-pitched ringing in the ears
<input type="checkbox"/> Bladder infections	<input type="checkbox"/> Frequent cavities	<input type="checkbox"/> Memory problems
<input type="checkbox"/> Easily broken bones	<input type="checkbox"/> Kidney stones	<input type="checkbox"/> Sore knees
<input type="checkbox"/> Easily startled	<input type="checkbox"/> Lack of bladder control	<input type="checkbox"/> Wake during the night twice or more to urinate
<input type="checkbox"/> Excessive hair loss	<input type="checkbox"/> Low back pain	<input type="checkbox"/> Weak knees

Urination:

<input type="checkbox"/> Burning	<input type="checkbox"/> Discharge	<input type="checkbox"/> Reddish
<input type="checkbox"/> Clear	<input type="checkbox"/> Frequent	<input type="checkbox"/> Scanty
<input type="checkbox"/> Cloudy	<input type="checkbox"/> Normal	<input type="checkbox"/> Strong odor
<input type="checkbox"/> Dark yellow	<input type="checkbox"/> Painful	<input type="checkbox"/> Urgent
<input type="checkbox"/> Difficult	<input type="checkbox"/> Profuse	

Libido:

<input type="checkbox"/> Normal	<input type="checkbox"/> High	<input type="checkbox"/> Low
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Women only:

Regular menstrual cycle? Yes No **Pregnant?** Yes No

Number of children: _____ Number of pregnancies: _____

Age of first menstruation: _____ Age of menopause (if applicable): _____

Average number days of flow: _____ Average number of days of entire cycle: _____

Vaginal discharge Yes No Bleeding between periods Yes No

Do you experience any of the following pre-menstrual syndromes?

<input type="checkbox"/>	Anxiety	<input type="checkbox"/>	Headaches	<input type="checkbox"/>	Dull pain. Where? _____
<input type="checkbox"/>	Breast swelling	<input type="checkbox"/>	Irritability	<input type="checkbox"/>	Sharp pain. Where? _____
<input type="checkbox"/>	Breast tenderness	<input type="checkbox"/>	Nausea	<input type="checkbox"/>	Other emotions: _____
<input type="checkbox"/>	Depression	<input type="checkbox"/>	Vomiting	<input type="checkbox"/>	_____
<input type="checkbox"/>	Food cravings	<input type="checkbox"/>	Water retention	<input type="checkbox"/>	_____

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:							

Men only:

<input type="checkbox"/>	Impotence	<input type="checkbox"/>	Premature ejaculation	<input type="checkbox"/>	Swollen testes	<input type="checkbox"/>	Testicular pain
<input type="checkbox"/>	Feeling of coldness or numbness in external genitalia			<input type="checkbox"/>	Other: _____		

IV. Allergies, Prescription Medications/Supplements, Stress, Nutrition

Please list any herb, drug or food allergies _____

Please list all medications (prescribed and OTC)/ herbs/ vitamins and supplements which you are currently taking:

Type	Dose	Reason Prescribed	Date Prescribed	Prescribed by	Date of last Check up

Please indicate the use, quantity and frequency of the following:

	Yes	No	Quantity	Frequency
Caffeinated Beverages				
Recreational Drugs				
Tobacco				
Alcohol				
Water Intake				
Soda				

How do you feel about the following areas in your life? (Please check the appropriate boxes and indicate any problems you may be experiencing)

	Great	Good	Fair	Poor	Bad	Comments
Significant Other						
Family						
Diet						
Sex						
Self						
Work						
Spirituality						

Have you had any major stresses in the last 6 months regarding:

Money
 Job
 Relationship
 Home Life
 Children
 Other: _____

Exercise Information:

	Yes	No	Comments
Do you exercise regularly?			
Do you allow time to unwind and Relax?			
Do you manage stress well?			
Do you sleep soundly?			

Nutrition Information

	Yes	No	Comments
Do you eat healthy foods?			
Do you eat three meals per day?			
Are you/have you been on a diet?			
Do you obsess about food?			
Do you have any food allergies?			
Do you have any particular food cravings?			

Typical Breakfast _____

Typical Lunch _____

Typical Dinner _____

Typical Snacks _____

