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 play a major role in diagnosis and treatment.

All information is strictly confidential.

I. General Patient Information

Date: ____/____/_____ Name: _____

Address: _____ City: _____

State: _____ Zip Code: _____ Email: _____

Cell #: (____) _____ Home #: (____) _____ Work #: (____) _____

Age: _____ Date of Birth: ____/____/____ Place of Birth: _____

Guardian (if under 18): _____

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

Occupation: _____ Employer: _____

Employer Address: _____ City: _____

State: _____ Zip Code: _____

Does anything limit you from care? [ ] Y [ ] N If yes, explain:

_____

How did you hear about our office? _____

Other physicians/therapists seen for this condition. _____

_____

Medications, if any: _____

Prescribed by: _____

Treatment and Results:

Supplements: (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 ☐ Blood ☐ Cholesterol ☐ Prostate ☐ HIV/STD

☐ Pap smear/Gynecological ☐ Mammography ☐ Other: _____

Test results and Date: _____

_____

Check any you have had in the past:

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

☐ other kidney illnesses ☐ other heart illnesses ☐ other stomach illnesses ☐ other spleen illnesses

☐ other: _____

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	☐	☐	

Where are you in the birth order? ☐ first ☐ last ☐ middle ☐ only

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 is pain and which are scars.

Is the pain:

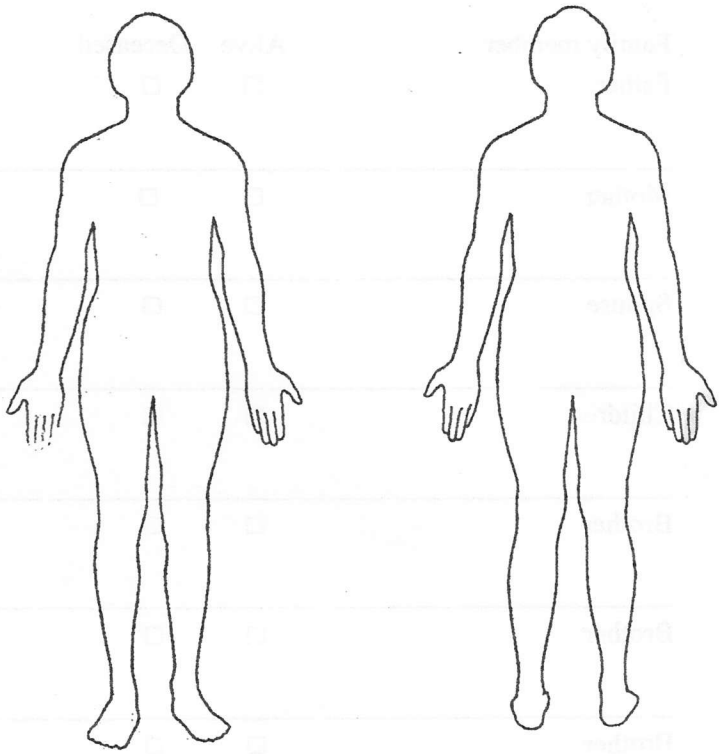
☐ Sharp ☐ Burning ☐ Aching
☐ Cramping ☐ Dull ☐ Moving
☐ Fixed ☐ Other: _____

Do the following lessen the pain?

☐ Pressure ☐ Cold ☐ Heat
☐ Exercise ☐ Other: _____

Do the following worsen the pain?

☐ Pressure ☐ Cold ☐ Heat
☐ Exercise ☐ Other: _____



Front Back

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 flushes
☐ Night sweats
☐ Heat in the hands, feet and chest
☐ Hot flashes any time of the day
☐ Thirsty
☐ Perspire easily
☐ Lack of perspiration
☐ Difficulty keeping eyes open in the daytime

Overall Energy Lung, Kidney function):

☐ Shortness of breath
☐ General weakness
☐ Easily catch colds
☐ Low energy
☐ Feel worse after exercise

Blood (Liver, Spleen, Heart function):

☐ Dizziness
☐ See floating spots

Heart function:

☐ Palpitations
☐ Anxiety
☐ Sores on the tip of the tongue
☐ Restlessness
☐ Mental confusion

Spleen, Stomach, Large Intestine, Small Intestine function:

☐ Loose stools
☐ Constipated
☐ Incomplete
☐ Diarrhea
☐ Blood in stools
☐ Mucous in stools
☐ Undigested food In stools

☐ Chest pain traveling to shoulder
☐ Frequent dreams
☐ Wake unrefreshed
☐ Drink coffee (# of cups/week: _____)

Lung function:
☐ Nasal discharge (color: _____)
☐ Cough
☐ Nosebleeds
☐ Snoring
☐ Dry mouth
☐ Dry throat
☐ Dry nose
☐ Dry skin
☐ Allergies (To what? _____)
☐ Alternating chills and fever
☐ Sneezing
☐ Headache (Location: _____
_____)
☐ Overall achy feeling in the body
☐ Stiff neck
☐ Stiff shoulders
☐ Sore throat
☐ Difficulty breathing
☐ Smoke cigarettes (#/day: _____)
☐ Sadness
☐ Melancholy

Spleen function:
☐ Low appetite
☐ Abrupt weight gain
☐ Abrupt weight loss
☐ Abdominal bloating
☐ Abdominal gas
☐ Gurgling in the stomach
☐ Fatigue after eating
☐ Prolapsed organs (which: _____)
☐ Easily bruised
☐ Hemorrhoids
☐ Pensive
☐ Over-thinking
☐ Worry

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

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

Liver, Gall Bladder function:
☐ Alternating diarrhea & 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 top of the head
☐ Tingling sensation
☐ Numbness
☐ Muscle spasms
☐ Muscle twitching
☐ Muscle cramping
☐ Seizures
☐ Convulsions
☐ 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
☐ Gall stones (history or current)
☐ Sexually transmitted disease
(Which? _____)

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

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

Kidney, 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 infections
☐ Wake during the night twice or more to urinate
☐ Lack of bladder control
☐ Fear
☐ Easily startled

Libido:
☐ Normal
☐ High
☐ Low

Other symptoms:

Women only:

Regular menstrual cycle? ☐Y ☐N
Number of children: _____
Age of first menstruation: _____
Average # of days of flow: _____

Pregnant? ☐Y ☐N
Number of pregnancies: _____
Age of menopause (if applicable): _____
Avg. # of days for entire cycle: _____

	Severe	Moderate	Slight	Normal
Vaginal discharge:	☐	☐	☐	☐
Bleeding between periods:	☐	☐	☐	☐

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

☐Nausea ☐Food cravings ☐Depression ☐Vomiting

☐Headaches ☐Irritability ☐Water retention ☐Migraines

☐Anxiety ☐Breast swelling ☐Breast tenderness ☐Other emotions: _____

☐Dull pain, where? _____ ☐Sharp pain, where? _____

☐Other: _____

Women, continued:

Please fill in the following menstrual chart:

circle what applies below ↓; check (√) which days apply →	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: dull, sharp, other							
Clots: large, small, black, purple, red, other							
Vomiting: (circle if yes)							
Nausea: (circle 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: _____	☐	☐	☐	☐

All please fill this out:

Other comments: _____

_____

_____

Patient signature: _____

Acupuncturist signature: _____