

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.

General Patient Information

Date: ____/____/____

Name: _____

Address: _____

City, State, Postal Code: _____

Home Phone: (____) _____ Work Phone: (____) _____

Cell: Phone: (____) _____ E-Mail: _____

Age: _____ Date of Birth: ____/____/____ Marital Status: M S D W

In Case of Emergency, Contact: _____ Phone No.: _____

Guardian (if under 18): _____

Gender: M F Height: ____' ____" Weight: _____ lbs. Soc. Sec. #: _____ - _____ - _____

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/Stays: _____

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:

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

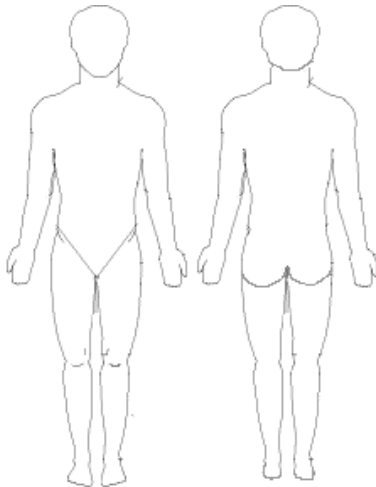
Other:

Immunizations: _____

Surgeries: _____

III. Patient Profile

After printing, please clearly mark any areas of pain and any scars:



Is the pain:

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

Does the following lessen the pain?

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

Does the following worsen the pain?

- | | | |
|-----------------------------------|-------------------------------|-------------------------------|
| Pressure <input type="checkbox"/> | Cold <input type="checkbox"/> | Heat <input type="checkbox"/> |
| Other: <input type="checkbox"/> | | |

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Please check the following that currently pertain to you (if you have symptoms in the following categories, it indicates that you have a problem with that organ's function):

Overall Temperature (Kidney function):

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

Overall energy (Lung, Kidney function):

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

Overall blood (Liver, Spleen, Heart function):

- | | |
|------------------------------------|---|
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> See floating black spots |
|------------------------------------|---|

Heart function:

- | | |
|---|---|
| <input type="checkbox"/> Palpitations | <input type="checkbox"/> Night sweats |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Chest pain traveling to shoulder |
| <input type="checkbox"/> Sores on the tip of the tongue | <input type="checkbox"/> Frequent dreams |
| <input type="checkbox"/> Restlessness | <input type="checkbox"/> Wake unrefreshed |
| <input type="checkbox"/> Mental confusion | |
| <input type="checkbox"/> Drink Coffee (# of cups per week: _____) | |

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Lung function:

- | | |
|--|---|
| <input type="checkbox"/> Nasal Discharge
(Color: _____) | <input type="checkbox"/> Smoke cigarettes (# of cigarettes
per day: _____) |
| <input type="checkbox"/> Cough | <input type="checkbox"/> Overall achy feeling in the body |
| <input type="checkbox"/> Nose Bleeds | <input type="checkbox"/> Stiff neck |
| <input type="checkbox"/> Sinus Congestion | <input type="checkbox"/> Stiff shoulders |
| <input type="checkbox"/> Dry mouth | <input type="checkbox"/> Sore throat |
| <input type="checkbox"/> Dry throat | <input type="checkbox"/> Difficulty breathing |
| <input type="checkbox"/> Dry Nose | <input type="checkbox"/> Sadness |
| <input type="checkbox"/> Dry Skin | <input type="checkbox"/> Melancholy |
| <input type="checkbox"/> Allergies (To what?:
_____) | <input type="checkbox"/> Headache (Location:
_____) |
| <input type="checkbox"/> Alternating fever and chills | <input type="checkbox"/> Sneezing |

Spleen function:

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

Spleen, Stomach, Large Intestine, Small Intestine function:

- | | |
|--------------------------------------|--|
| <input type="checkbox"/> Loose | <input type="checkbox"/> Diarrhea |
| <input type="checkbox"/> Constipated | <input type="checkbox"/> Blood in stools |
| <input type="checkbox"/> Incomplete | |

Spleen, Stomach, Large Intestine, Small Intestine function:

- | | |
|---|--|
| <input type="checkbox"/> Mucous in stools | <input type="checkbox"/> Undigested food in stools |
|---|--|

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Dampness trapped in the body:

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

Stomach function:

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

Liver, Gall Bladder function:

- | | |
|--|---|
| <input type="checkbox"/> Alternating diarrhea and constipation | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Chest pain | <input type="checkbox"/> Irritability |
| <input type="checkbox"/> Tight sensation in the chest | <input type="checkbox"/> Frequently unable to adapt to stress
(What causes the stress?
_____) |
| <input type="checkbox"/> Bitter taste in the mouth | <input type="checkbox"/> Skin rashes |
| <input type="checkbox"/> Anger easily | <input type="checkbox"/> Headache at the top of the head |
| <input type="checkbox"/> Frustration | <input type="checkbox"/> Tingling sensation |

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Liver, Gall Bladder function:

- | | |
|---|--|
| <input type="checkbox"/> Numbness | <input type="checkbox"/> Limited Range-of-Motion, Neck |
| <input type="checkbox"/> Muscle spasms | <input type="checkbox"/> Shoulder tension |
| <input type="checkbox"/> Muscle twitching | <input type="checkbox"/> Limited Range-of-Motion, Shoulder |
| <input type="checkbox"/> Muscle cramping | <input type="checkbox"/> Drink alcohol |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Recreational drugs
(Which? _____,
How much per week? _____) |
| <input type="checkbox"/> Convulsions | <input type="checkbox"/> High-pitched ringing in the ears |
| <input type="checkbox"/> Lump in the throat | <input type="checkbox"/> Gall stones (history or current) |
| <input type="checkbox"/> Neck tension | <input type="checkbox"/> Sexually transmitted disease
(Which? _____) |

Eyes (Liver function):

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

Kidney, Urinary Bladder function:

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

Kidney, Urinary Bladder function:

- | | |
|--|--|
| <input type="checkbox"/> Lack of bladder control | <input type="checkbox"/> Easily startled |
| <input type="checkbox"/> Fear | |

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Urination:

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

Libido:

- | | |
|---------------------------------|-------------------------------|
| <input type="checkbox"/> Normal | <input type="checkbox"/> High |
| <input type="checkbox"/> Low | |

HEALTH HISTORY QUESTIONNAIRE

Women only:

- Regular menstrual cycle? Y N Pregnant? Y N
 Number of children: _____ Number of pregnancies: _____
 Age of first menstruation: _____ Age of menopause (if applicable): _____
 Average number of days of flow: _____ Average number of days of entire cycle: _____
 Vaginal discharge Bleeding between periods

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

- Nausea Vomiting Water Retention Breast Swelling
 Food Cravings Headaches Migraines Breast Tenderness
 Depression Irritability Anxiety Other
 Dull Pain, where? _____ Emotions: _____
 sharp 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							

HEALTH HISTORY QUESTIONNAIRE

Men only:

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

All please fill out:

Other Comments: _____

Patient Signature: _____

Acupuncturist Signature: _____