

HEALTH HISTORY QUESTIONNAIRE FOR PATIENTS

Welcome to our clinic! Please help us provide you with a complete evaluation by taking the time to fill out this questionnaire carefully. All your answers will be held absolutely confidential. If you have questions, please ask us. If there is anything you wish to bring to our attention which is not asked on this form, please note it in the **comments** section. Thank you!

Name: _____

Street: _____

City: _____

State: _____

Zip: _____

Age: _____

Height: _____

Weight: _____

Email: _____

Home

Cell

Work

Phone: _____

Phone: _____

Phone: _____

Date of Birth: _____

Social Security Number: _____

Occupation: _____

Marital Status: _____

In Emergency Notify: _____

Referred by: _____

Family Physician: _____

Insurance Carrier: _____

Have you tried acupuncture or Chinese herbal medicine before? _____

WHAT IS YOUR MAIN PROBLEM? (please explain)

To what extent does this problem affect your daily activities (work, sleep, eating, etc)? _____

How long has it been since you first noticed symptoms? _____

Have you been given a diagnosis for the problem by your family physician? _____

If so, what is it? _____

What kinds of treatment or therapy have you tried? _____

PAST MEDICAL HISTORY (PLEASE INCLUDE DATES)

Allergies: _____

Rheumatic fever _____

Other significant illness _____

Cancer _____

Surgeries _____

(describe) _____

Diabetes _____

Venereal disease _____

Hepatitis _____

Thyroid disease _____

High blood pressure _____

Birth trauma (prolonged
labor, forceps delivery, etc) _____

Accidents or significant
trauma (describe) _____

Heart disease _____

Seizures _____

OTHER RELEVANT MEDICAL HISTORY

FAMILY MEDICAL HISTORY

- | | | |
|-------------------------------------|--|-----------------------------------|
| <input type="checkbox"/> Allergies: | <input type="checkbox"/> Cancer | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart disease | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Other |

OCCUPATION

Occupational stress factors (physical, psychological, chemical):

LIFESTYLE

Do you follow a regular exercise program?

If so, please describe:

Please describe your average daily diet:

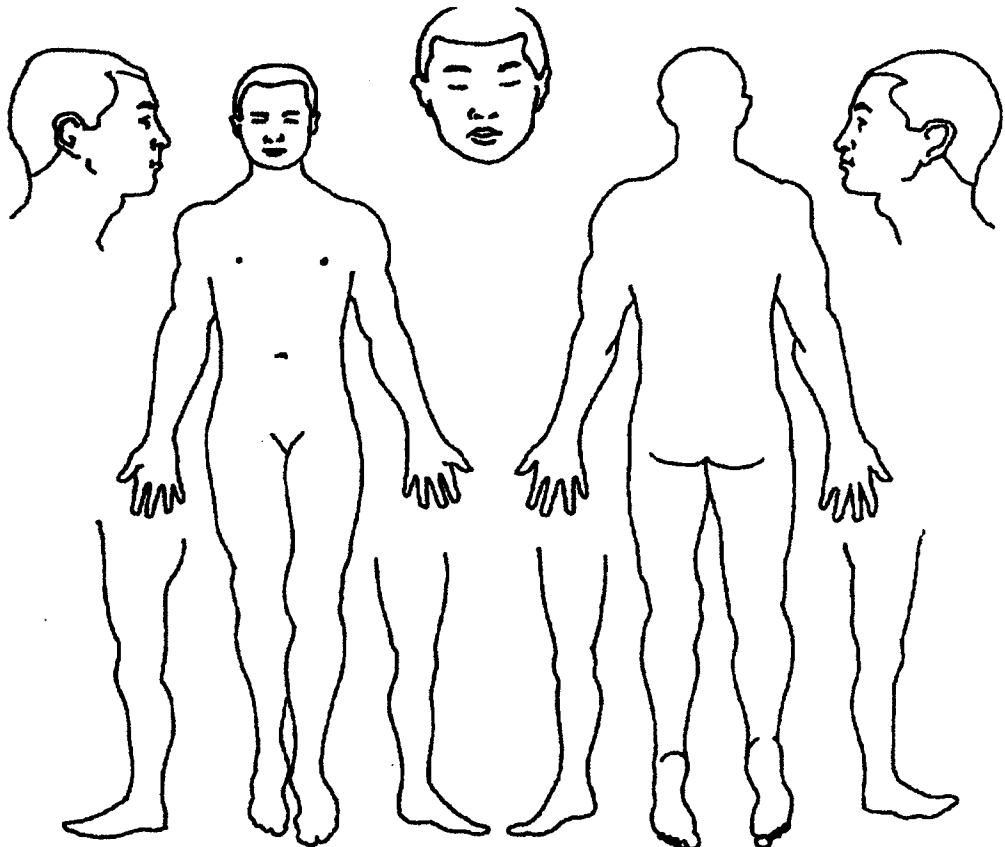
Please check any of the following habits that apply. How much and how often do you use them?

- | | | |
|--|--|--|
| <input type="checkbox"/> Cigarette smoking | <input type="checkbox"/> Coffee, tea or cola | <input type="checkbox"/> Alcoholic beverages |
|--|--|--|

List medications taken within the last two months (vitamins, drugs, herbs, etc.):

Please describe any use of drugs for non-medical purposes:

Symbol	Reaction
Pain on pressure	
x	little
xx	moderate
xxx	strong
Swelling	
^	slight
^^	moderate
^^^	severe
Tension/weakness	
~	weak
#	tense
Spontaneous pain	
†	slight
††	moderate
†††	severe
Pulsing	
o	slight
oo	moderate
ooo	strong
Temperature	
-	colder
+	hotter
Physical	
∅	sores
*	rashes
<<>>	spasms



CHECK NEXT TO ANY CONDITIONS YOU HAVE EXPERIENCED WITHIN THE LAST THREE MONTHS. INDICATE THE LENGTH OF TIME YOU HAVE HAD THIS CONDITION.

GENERAL

- | | | |
|---|--|---|
| <input type="checkbox"/> Poor appetite | <input type="checkbox"/> Weight gain | <input type="checkbox"/> Night sweats |
| <input type="checkbox"/> Insomnia | <input type="checkbox"/> Weight loss | <input type="checkbox"/> Fever |
| <input type="checkbox"/> Disturbed sleep | <input type="checkbox"/> Changes in appetite | <input type="checkbox"/> Chills |
| <input type="checkbox"/> Localized weakness | <input type="checkbox"/> Sweating easily | <input type="checkbox"/> Sudden energy drop
(time of day?) |
| <input type="checkbox"/> Cravings | <input type="checkbox"/> Tremors | <input type="checkbox"/> Poor balance |
| <input type="checkbox"/> Strong thirst | <input type="checkbox"/> Bleeding or bruising easily | |

Other unusual or abnormal conditions you have noticed in you general sense of health

SKIN AND HAIR

- | | | |
|--------------------------------------|------------------------------------|--|
| <input type="checkbox"/> Rashes | <input type="checkbox"/> Eczema | <input type="checkbox"/> Recent moles |
| <input type="checkbox"/> Ulcerations | <input type="checkbox"/> Pimples | <input type="checkbox"/> Changes in texture of hair
or skin |
| <input type="checkbox"/> Hives | <input type="checkbox"/> Dandruff | |
| <input type="checkbox"/> Itching | <input type="checkbox"/> Hair loss | |

Any other hair or skin problems

HEAD, EYES, EARS, NOSE, THROAT

- | | | |
|---|--|---|
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Color blindness | <input type="checkbox"/> Recurrent sore throat |
| <input type="checkbox"/> Concussions | <input type="checkbox"/> Cataracts | <input type="checkbox"/> Nose bleeds |
| <input type="checkbox"/> Migraines | <input type="checkbox"/> Blurry vision | <input type="checkbox"/> Grinding teeth |
| <input type="checkbox"/> Glasses | <input type="checkbox"/> Earaches | <input type="checkbox"/> Sores on lips or tongue |
| <input type="checkbox"/> Spots in front of eyes | <input type="checkbox"/> Ringing in ears | <input type="checkbox"/> Facial pain |
| <input type="checkbox"/> Eye pain | <input type="checkbox"/> Poor hearing | <input type="checkbox"/> Teeth problems |
| <input type="checkbox"/> Poor vision | <input type="checkbox"/> Eye strain | <input type="checkbox"/> Headaches (where? when?) |
| <input type="checkbox"/> Night blindness | <input type="checkbox"/> Sinus problems | <input type="checkbox"/> Jaw clicks |

Any other head or neck problems

CARDIOVASCULAR

- | | | |
|--|--|--|
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Swelling of feet |
| <input type="checkbox"/> Low blood pressure | <input type="checkbox"/> Fainting | <input type="checkbox"/> Blood clots |
| <input type="checkbox"/> Chest pain | <input type="checkbox"/> Cold hands or feet | <input type="checkbox"/> Difficulty in breathing |
| <input type="checkbox"/> Irregular heartbeat | <input type="checkbox"/> Swelling of hands | <input type="checkbox"/> Phlebitis |

Any other heart or blood vessel problems

RESPIRATORY

- | | | |
|--|--|--|
| <input type="checkbox"/> Cough | <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Difficulty breathing when
lying down |
| <input type="checkbox"/> Coughing up blood | <input type="checkbox"/> Pain with deep inhalation | <input type="checkbox"/> Excessive phlegm (color?) |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Pneumonia | |

Any other lung problems

GASTROINTESTINAL

- | | | |
|---------------------------------------|--|---|
| <input type="checkbox"/> Nausea | <input type="checkbox"/> Belching | <input type="checkbox"/> Rectal pain |
| <input type="checkbox"/> Vomiting | <input type="checkbox"/> Black stools | <input type="checkbox"/> Hemorrhoids |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Blood in stools | <input type="checkbox"/> Abdominal pain or cramps |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Indigestion | <input type="checkbox"/> Chronic laxative use |
| <input type="checkbox"/> Gas | <input type="checkbox"/> Bad breath | |

Any other problems with stomach or intestines

GENITOURINARY

- | | | |
|---|---|--|
| <input type="checkbox"/> Pain on urination | <input type="checkbox"/> Urgency to urinate | <input type="checkbox"/> Decrease in flow |
| <input type="checkbox"/> Frequent urination | <input type="checkbox"/> Unable to hold urine | <input type="checkbox"/> Impotence |
| <input type="checkbox"/> Blood in urine | <input type="checkbox"/> Kidney stones | <input type="checkbox"/> Sores on genitals |

Do you wake up at night to urinate? If so, how often?

Any particular color to your urine?

Any other genital or urinary problems:

REPRODUCTIVE AND GYNECOLOGIC

- | | | |
|---|---|---|
| <input type="checkbox"/> Premenstrual changes | <input type="checkbox"/> Heavy menstrual flow | <input type="checkbox"/> Premature births |
| <input type="checkbox"/> Menstrual clots | <input type="checkbox"/> Light menstrual flow | <input type="checkbox"/> Miscarriages |
| <input type="checkbox"/> Painful menses | <input type="checkbox"/> Irregular menses | <input type="checkbox"/> Abortions |
| <input type="checkbox"/> Unusual menses | <input type="checkbox"/> Other problems | |

Age at first menses

Age at menopause

Number of pregnancies

Time between cycles

Duration of bleeding

First day of last menses

Do you practice birth control?

If so, what type?

For how long?

Any other gynecologic problems

MUSCULOSKELETAL

- | | | |
|---------------------------------------|---|---|
| <input type="checkbox"/> Neck pain | <input type="checkbox"/> Back pain | <input type="checkbox"/> Hand/wrist pains |
| <input type="checkbox"/> Muscle pains | <input type="checkbox"/> Muscle weakness | <input type="checkbox"/> Shoulder pain |
| <input type="checkbox"/> Knee pain | <input type="checkbox"/> Foot/ankle pains | <input type="checkbox"/> Hip pain |

Any other joint or bone problems

NEUROPSYCHOLOGICAL

- | | | |
|--|---|---|
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Poor memory | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Lack of coordination | <input type="checkbox"/> Bad temper |
| <input type="checkbox"/> Loss of balance | <input type="checkbox"/> Concussion | <input type="checkbox"/> Easily susceptible to stress |
| <input type="checkbox"/> Areas of numbness | <input type="checkbox"/> Depression | |

Have you ever been treated for emotional problems?

Have you ever considered or attempted suicide?

Any other neurological problems

COMMENTS

Please list any other problems you would like to discuss: