Name: Date:

HEALTH HISTORY QUESTIONNAIRE

Please help us provide you with a complete evaluation by taking the time to fill out this questionnaire carefully. *All of your answers will be held absolutely confidential*. If you have questions, please ask. 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____Date______________

Street_____________________________City__________________State/Zip_______________

Home Phone________________Work Phone_______________eMail ____________________

Age_____Date of Birth___________Male____Female____Height_______Weight___________

Marital Status: ☐ Married ☐ Never Married ☐ Widowed ☐ Divorced or Separated

Education: ☐ Grammar School ☐ High School ☐ College ☐ Masters ☐ Doctorate

Occupation:_____________________Retired:_______Disabled:_______Unemployed:_______

Family Physician:_____________________________Referred by:_________________________

Emergency Contact:____________________Emergency Contact Relation to you:____________

Emergency Contact telephone:____

Have you ever been treated by acupuncture or Oriental medicine before? ☐ Yes ☐ No

Main Problem you would like us to help you with:____________________________________

____

____

____

____

____

How long ago did this problem begin? Please be specific: _____________________________

____

____

Name: Date:

Have you been given a diagnosis for this problem? If so, what diagnosis and by whom?

____

What other kinds of treatment have you tried?

□ Western Medicine □ Acupuncture

□ Herbs □ Massage □ Physical Therapy □ Chiropractor □ Reiki □ Homeopathy

□ Other:____

How confident are you that Acupuncture and Chinese herbal medicine will be able to resolve the symptoms of your main complaint?

□ Not confident □ Slightly confident □ Moderately confident □ Confident □ Very confident

Secondary Complaints you would like us to help you with:______________________________

____

____

____

Past Personal Medical History of Significant Illnesses: □ Asthma □ Allergies □ Diabetes

□ Cancer □ Stroke □ Heart disease □ High Blood Pressure □ Seizures □ Hepatitis

□ Rheumatic Fever □ Thyroid disease □ Venereal disease Other:______________________

____

____

Hospitalizations/Surgeries (including dates):____

____

____

____

Significant Trauma (auto accidents, falls, etc.):_______________________________________

____

Allergies (drugs, chemicals, metals, foods):____

____

Family Medical History: (check all that are applicable) □ Asthma □ Allergies □ Diabetes

□ Cancer □ Stroke □ Heart disease □ High Blood Pressure □ Seizures □ Thyroid

□ Hepatitis □ Rheumatic Fever □ Thyroid disease □ Venereal disease

□ Other:____

____

Name: Date:

Medicines taken within the last two months (vitamins, drugs, herbs, etc.):___________________

____

____

Are there any areas of your life that you find stressful? Please describe:____________________

____

Do you have a regular exercise program? □ No □ Yes If yes, please describe:_______________

____

Do you follow any type of special diet (e.g. vegetarian, vegan, medical related, or other)?
□ No □ Yes If Yes, what type of diet? ____

Describe your average daily diet:
Morning:____
Afternoon:____
Evening: ____

Do you smoke? □ No □ Yes If Yes, how many cigarettes or cigars per day? ____________

How many cups of caffeinated coffee, tea, or cola do you drink per week?__________________

How many 8 oz. glasses of water do you drink per day?__________________________________

How many alcoholic beverages do you drink per week?___________________________________

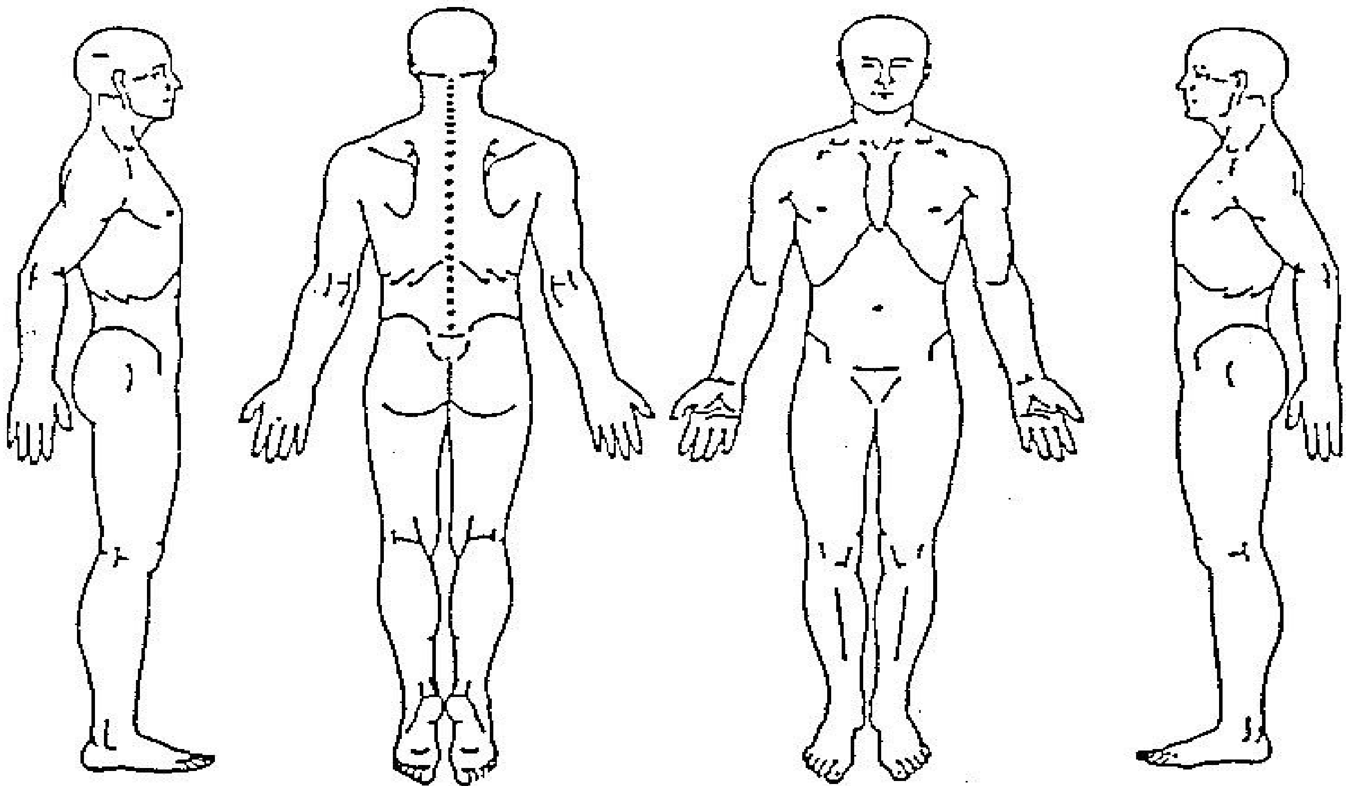
Please describe any use of drugs for non-medical purposes:_______________________________

____

____

Name: Date:

Please indicate any painful or distressed body areas by circling the particular area:



Please check if you have had any of the following, particularly if in the last three months: GENERAL:

- ◻ Fevers ◻ Chills ◻ Fatigue ◻ Sweat easily
- ◻ Poor sleeping ◻ Night sweats ◻ Weight loss ◻ Cravings
- ◻ Weight gain ◻ Change in appetite ◻ Strong thirst for: ◻ Hot drinks ◻ Cold drinks
- ◻ Sudden energy drop, if so what time of day?________________________________
- ◻ Bleed or bruise easily ◻ Peculiar tastes or smells

SKIN & HAIR:

- ◻ Rashes ◻ Ulcerations ◻ Hives ◻ Itching
- ◻ Eczema ◻ Pimples ◻ Dandruff ◻ Loss of hair
- ◻ Recent moles ◻ Psoriasis ◻ Dermatitis ◻ Acne
- ◻ Change in hair or skin texture
- ◻ Any other skin or hair problems?____

Name: Date:

HEAD, EYES, EARS, NOSE & THROAT:

- ◻ Dizziness ◻ Concussions ◻ Migraines ◻ Glasses
- ◻ Eye strain ◻ Eye pain ◻ Poor vision ◻ Night blindness
- ◻ Color blindness ◻ Cataracts ◻ Blurry vision ◻ Earaches
- ◻ Ringing in ears ◻ Spots in front of eyes ◻ Poor hearing ◻ Sinus problems
- ◻ Nose bleeds ◻ Recurrent sore throats ◻ Grinding teeth ◻ Clenching jaw
- ◻ Facial pain ◻ Sores on lips or tongue ◻ Teeth problems ◻ Jaw clicks
- ◻ Headaches, where and when?____
- ◻ Any other head or neck problems?_______________________________________

CARDIOVASCULAR:

- ◻ High blood pressure ◻ Low blood pressure ◻ Chest pain ◻ Fainting
- ◻ Irregular heart beat ◻ Difficulty in breathing ◻ Blood clots ◻ Phlebitis
- ◻ Cold hands or feet ◻ Swelling of hands ◻ Swelling of feet
- ◻ Varicose or spider veins ◻ Palpitations ◻ Palpitations at rest
- ◻ Any other heart of blood vessel problems?_________________________________

RESPIRATORY:

- ◻ Cough ◻ Coughing blood ◻ Asthma ◻ Bronchitis
- ◻ Pneumonia ◻ Pain with deep breath ◻ Chest tightness
- ◻ Difficulty breathing when lying down
- ◻ Phlegm production, what color?____

GASTROINTESTINAL:

- ◻ Nausea ◻ Vomiting ◻ Diarrhea ◻ Constipation
- ◻ Gas ◻ Belching ◻ Black stools ◻ Blood in stools
- ◻ Indigestion ◻ Bad breath ◻ Rectal pain ◻ Hemorrhoids
- ◻ Bleeding gums ◻ Food stagnation ◻ Bloating/edema ◻ Acid reflux/GERD
- ◻ Hernia ◻ Excessive appetite ◻ Poor appetite ◻ IBS/Crohn's disease
- ◻ Colitis ◻ Slow digestion ◻ Abdominal pain/cramps
- ◻ Chronic laxative use ◻ Loose stools, more than 2 per day
- ◻ Any other problem with Stomach or intestines_____________________________

GENITO-URINARY:

- ◻ Frequent urination ◻ Blood in urine ◻ Pain upon urination
- ◻ Urgency to urinate ◻ Unable to hold urine ◻ Kidney stones
- ◻ Decrease in flow ◻ Impotency ◻ Sores on genitals
- ◻ Any particular color to your urine? ______________________
- ◻ Do you wake up at night to urinate? If yes, how many times a night? ____________
- ◻ Any other problems with your genital or urinary systems?____________________

Name: Date:

EPRODUCTIVE & GYNECOLOGIC:

Are you pregnant? □ Yes □ No

Is it possible that you are pregnant? □ Yes □ No

Number of pregnancies: ____________ Live Births: ___________ Miscarriages: __________

Abortions:_________________________ Premature births:___________________________________

Age at first menses: ________________ Time period between menses:______________________

Duration of menses:________________ Last PAP: ____

□ Irregular periods □ Painful periods □ Clots □ Breast lumps

□ Vaginal sores □ Vaginal discharge □ Vaginal dryness □ Endometriosis

□ Uterine fibroids □ Polycystic Ovarian disease □ Fibrocystic breast tissue

□ Unusual character of blood (heavy, scanty)____

Do you practice birth control? □ Yes □ No If yes, what type?___________How long? ___________

MUSCULOSKELETAL:

□ Neck pain □ Rotator cuff □ Knee pain □ Foot/ankle pain

□ Muscle pain □ Muscle spasm □ Muscle weakness □ Shoulder pain

□ Hip pain □ Sciatica □ Bursitis □ Hand/wrist pain

□ Carpal tunnel □ Sprains/strains □ Tendonitis

□ Back pain: Low______Middle_______Upper______

□ Soreness/weakness of lower body (back, hip, knee, ankle, foot)

NEUROLOGICAL & PSYCHOLOGICAL:

□ Seizures □ Dizziness □ Loss of balance □ Areas of numbness

□ Poor memory □ Concussion □ Poor coordination □ Bad temper

□ Anxiety □ Depression □ Easily susceptible to stress

□ Nervousness □ ADD/ADHD □ Manic depression

Have you ever been treated for emotional problems? □ Yes □ No

Have you ever considered or attempted suicide? □ Yes □ No

Any other neurological or psychological problems? ____

____

COMMENTS: *Please tell us briefly of any other problems you would like to discuss.*

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