

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.

I. General Patient Information

Date: ___/___/___

Name: _____

Address: _____

City, State, Zip: _____ Email: _____

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

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

Guardian (if under 18): _____

Gender: ___M ___F Height: ___'___" Weight: _____ lbs.

Occupation: _____ Employer: _____

How did you hear about our office? _____

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

- | | |
|----------|----------|
| 1. _____ | 4. _____ |
| 2. _____ | 5. _____ |
| 3. _____ | 6. _____ |

How do these conditions impair your daily activities? _____

II. Patient Medical History

How was your childhood health? _____

List ALL Scars/Surgeries (include organ removal, tonsillectomy, circumcision, episiotomy, major cuts or burns, etc – Anything that could cause internal or external scarring)

List ANY root canals, crowns, implants, or major dental problems past or present

Recent tests: (please circle any tests that had an abnormal value)

___Physical ___Cholesterol ___Prostate ___Blood (which?)

__ HIV/STD

__ Pap smear

__ Mammography

__ Other: _____

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 illnesses |
| <input type="checkbox"/> other: _____ | | | |

Immunizations: _____

List all medications (including vitamins, herbs, tylenol, etc) _____

III. Patient Profile

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

Is the pain:

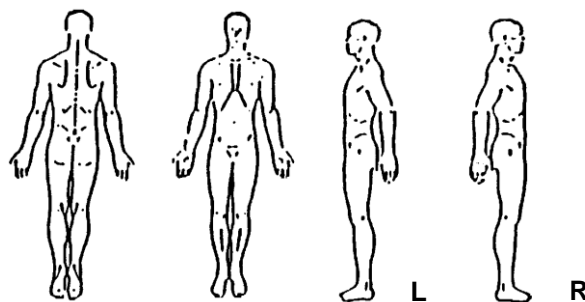
- | | | |
|-----------------------------------|--------------------------------------|---------------------------------|
| <input type="checkbox"/> Sharp | <input type="checkbox"/> Burning | <input type="checkbox"/> Aching |
| <input type="checkbox"/> Cramping | <input type="checkbox"/> Dull | <input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

Do the following lessen the pain?

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

Do the following worsen the pain?

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



Please check the following that currently (past 6 months) pertain to you. If you have symptoms in the following categories, it indicates that may you have a problem with that organ's function):

Overall Temperature (Kidney function):

- Cold hands/fingers
- Cold feet/toes
- Sweaty hands
- Sweaty feet
- Tendency to feel warm/hot body temperature (sensation)
- Tendency to feel cool/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
- Take water to bed to drink

Overall energy (Lung, Kidney function):

- Shortness of breath
- Difficulty keeping eyes open in the daytime
- General weakness
- Easily catch colds
- Low energy
- Feel worse after exercise

Overall blood (Liver, Spleen, Heart function):

- Dizziness
- See floating black spots or flashes of light

Heart function:

- Palpitations
- Anxiety
- Sores on the tip of the tongue
- Restlessness
- Mental confusion
- Chest pain traveling to shoulder
- Frequent dreams
- Wake unrefreshed
- Drink coffee (# of cups per week: _____)

Lung function:

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

Spleen function:

- Low appetite
- Abrupt weight gain
- Abrupt weight loss
- Abdominal bloating
- Abdominal gas
- Gurgling noise in the stomach
- Fatigue after eating
- Prolapsed organs (previously diagnosed, which organ? _____)
- Easily bruised
- Hemorrhoids
- Pensive/Disposed to frequent serious thought
- Over-thinking or Tendency to Worry

Spleen, Stomach, Large Intestine, Small Intestine function:

- Loose
- Constipated
- Incomplete
- Diarrhea
- Blood in stools
- Mucous in stools
- Undigested food in stools

Dampness trapped in the body:

- General sensation of heaviness in the body
- Mental heaviness
- Mental sluggishness/fogginess
- Swollen hands
- Swollen feet
- Swollen joints
- Chest congestion
- Nausea
- Snoring

Stomach function:

- Burning sensation after eating
- Large appetite
- Bad breath
- Mouth (canker) sores
- Bleeding, swollen or painful gums (Including bleeding after brushing)
- Heartburn
- Acid regurgitation
- Ulcer (diagnosed)
- Belching
- Hiccoughs
- Stomach pain
- Vomiting

Liver, Gall Bladder function:

- Alternating diarrhea and 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 the 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 (previous or current)
- Sexually transmitted disease (Which? _____)

Eyes (Liver function):

- Itchy
- Bloodshot
- Hot
- Dry
- Watery
- Gritty
- Blurry vision
- Decreased night vision
- Near/Far sighted

Kidney, Urinary 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

Urination:

- Normal color
- Dark yellow
- Clear
- Reddish
- Cloudy
- Scanty (low quantity)
- Profuse (high quantity)
- Strong odor
- Burning
- Painful
- Discharge
- Difficult
- Urgent
- Frequent

Hormonal and Reproductive function:

Libido (sex drive):

- None
- Low
- Normal
- High

Men only:

Swollen testes Testicular pain Premature ejaculation
 Feeling of coldness or numbness in external genitalia
 Difficulty achieving or maintaining an erection Difficulty starting/stopping urination
Other _____

Women only:

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

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 emotions: _____
 dull pain, where? _____ sharp pain, where? _____

Please fill in the following menstrual chart:

| <i>Circle applicable items below</i> | 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 (circle if yes) | | | | | | | |
| Nausea (circle if yes) | | | | | | | |
| Other (write in if needed) | | | | | | | |

Both Men and Women, please fill out:

Other Comments or Symptoms not mentioned: _____

Patient Signature: _____