

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, 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? _____

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

Immunizations: _____

Surgeries: _____

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 | Other: _____ | |

Do the following lessen the pain?

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

Do the following worsen the pain?

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

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):

- Cold hands
 - Cold fingers
 - Cold feet
 - Cold toes
 - 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
- Take water to bed

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

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
- Over-thinking
- 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
- Mental foginess
- 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
- 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 (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

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
 - Profuse
 - Strong odor
 - Burning
 - Painful
-

- Discharge
- Difficult
- Painful
- Urgent
- Frequent

Libido:

- Normal
 - High
 - Low
-

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 emotions: _____

dull pain, where? _____

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							

Men only:

Swollen testes

Testicular pain

Impotence

Premature ejaculation

Feeling of coldness or numbness in external genitalia

Other _____

All please fill out:

Other Comments: _____

Patient Signature: _____

Acupuncturist Signature: _____