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, and Postal Code:
_____

Home Phone: _(_____)_____ Work Phone:
_(_____)_____

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

Guardian (if under 18):
_____

Gender: ☐M ☐F Height: ____'____" Weight: _____lbs.

Social Security Number: _____-_____-_____ Driver's License Number:_____

Occupation:_____Employer:_____
__

How did you hear about our office? _____

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

1. _____
2. _____
3. _____
4. _____
5. _____

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:

☐Diabetes	☐Allergies	☐Glaucoma	☐Rheumatic Fever
☐Heart Disease	☐CVA (stroke)	☐Vein condition	☐Thyroid disorder
☐Asthma	☐Pneumonia	☐Tuberculosis	☐Emphysema
☐Jaundice	☐Gonorrhea	☐Mumps	☐Bleeding tendency
☐Syphilis	☐Measles	☐Chicken pox	☐Nervous disorder
☐Meningitis	☐HIV	☐Polio	☐Mononucleosis
☐Epilepsy	☐High fever	☐Hepatitis	☐Multiple Sclerosis
☐Paralysis	☐Cancer	☐Migraines	☐High blood pressure
☐Other lung illnesses	☐other liver illnesses	☐other heart illnesses	☐other kidney illnesses

☐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:

☐Sharp	☐Burning	☐Aching
☐Cramping	☐Dull	☐Moving
☐Fixed	Other:_____	

Do the following lessen the pain?

☐Pressure	☐Cold	☐Heat
☐Exercise	☐Other:_____	

Do the following worsen the pain?

☐Pressure	☐Cold
☐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 feet
- ☐Sweaty hands
- ☐Hot body temperature (sensation)
- ☐Afternoon flushes
- ☐Heat in the hands, feet, and chest
- ☐Thirsty
- ☐Lack of perspiration
- ☐Cold fingers
- ☐Cold toes
- ☐Sweaty feet
- ☐Cold body temperature (sensation)
- ☐Night sweats
- ☐Hot flashes any time of the day
- ☐Perspire easily
- ☐Take water to bed

Overall energy (Lung, Kidney function):

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

Overall blood (Liver, Spleen, Heart function):

- ☐Dizziness
- ☐See floating black spots

Heart function:

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

Lung function:

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

Spleen function:

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

Spleen, Stomach, Large Intestine, Small Intestine function:

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

Dampness trapped in the body:

☐General sensation of heaviness in the body ☐Mental heaviness
☐Mental sluggishness ☐Mental 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 ☐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 2x 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 ☐Urgent
☐Frequent

Libido: ☐Normal ☐High ☐Low

***Women only*:**

Pregnant?☐Y ☐N Regular menstrual cycle?☐Y ☐N Date of most recent cycle_____
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: _____