

**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 may play a major role in diagnosis and treatment.

All information is strictly confidential.

I. GENERAL PATIENT INFORMATION

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Name:

Address:

City, State, Zip Code:

Home Phone: \_\_\_\_\_

Work Phone:

Email address:

Age: \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Place of Birth:

Guardian (if under 18 years of age):

Gender:

M

F

Height: \_\_\_\_' \_\_\_\_"

Weight: \_\_\_\_\_ lbs.

Marital Status:

Occupation: \_\_\_\_\_

Employer:

How did you hear about our office?

Family Physician: \_\_\_\_\_

Phone:

Insurance Company: \_\_\_\_\_

Policy #:

Emergency Contact Name, Phone Number and Relation to Patient:

Have you ever been treated by Acupuncture or Oriental Medicine before? Yes

No

Main Conditions you would like us to help you with, in order of significance:

1.

4.

2.

5.

3.

6.

How long ago did these problem(s) begin, please be specific:

To what extent do these problems affect your daily activities, such as work, sleep or hobbies?

What kinds of treatment have you tried, and how have they worked?

Have you been given a diagnosis for any of these problems, if so, what?

## II. PAST MEDICAL HISTORY

How was your childhood health?

List all Hospitalizations, Surgeries, Auto Accidents, Trauma, Falls:

Allergies (food, seasonal, environmental):

**Recent Tests** (Please indicate test results and date):

Physical	Cholesterol	Prostate	Blood (which)	HIV/STD
Pap Smear	Mammography	Other: _____		

Test Results and Date:

**Circle any you have had in the past:**

Diabetes (Stroke)	Allergies	Glaucoma	Rheumatic Fever	Heart Disease	CVA
Vein condition	Asthma	Pneumonia	Tuberculosis	Emphysema	
Mumps	Gonorrhea	Syphilis	Bleeding Tendency	Measles	
Jaundice	Chicken Pox	Epilepsy	Nervous Disorder	High Fever	
High Fever					
Meningitis					
Hepatitis					
Mononucleosis	HIV/AIDS	Polio	Thyroid Disorder	Paralysis	
Cancer					
Migraines	Diabetes	Hepatitis	High Blood Pressure	Lung Disorder	Liver
Disorder					
Kidney Disorder		Spleen Disorder		Stomach Disorder	
Other:					

Immunizations:

**Family Medical History:** Please circle all that apply in your immediate family



θ See floaters or floating black spots in the eyes    θ Recent moles, unusual moles  
θ Freckles    θ Dizziness    θ Pimples

Heart Function:

θ Cardiovascular disease    θ High blood pressure    θ Low blood pressure  
θ Chest pain    θ Fainting    θ Palpitations    θ Sores on tip of tongue  
θ Restlessness    θ Anxiety    θ Hard to fall asleep    θ Wake unrefreshed  
θ Nightmares    θ Restless sleep    θ Mental Confusion    θ Restless dreaming  
θ Waking during the night    θ Chest pain traveling to shoulders or down arms

Lung Function:

θ Profuse nasal discharge:    thin/clear/runny    thick/white    thick/yellow  
θ Cough: Wet or Dry    θ Nose Bleeds    θ Sinus Congestion    θ Dry mouth  
θ Dry, itchy throat    θ Sore throat    θ Dry skin    θ Allergies: to what?  
θ Sneezing    θ Hives    θ Stiff neck    θ Stiff shoulders  
θ Bronchitis    θ Rashes    θ Itching    θ Eczema  
θ Dandruff    θ Sadness    θ Melancholy    θ Difficulty inhale or exhale  
θ Alternating fever and chills    θ Achy feeling in the body    θ Smoke cigarettes

Spleen Function:

θ Low appetite    θ Changes in appetite    θ Cravings, for what?  
θ Abrupt weight gain    θ Abrupt weight loss    θ Abdominal bloating  
θ Abdominal gas    θ Stomach Gurgling    θ Fatigue after eating  
θ Easily bruised    θ Hemorrhoids    θ Pensive/Over-thinking  
θ Worry    θ Prolapsed organs: which organ?

Spleen, Stomach, Large Intestine, Small Intestine Function:

θ Loose Stools    θ Incomplete Bowel Movements    θ Constipation  
θ Diarrhea    θ Blood in Stools    θ Undigested food in stools  
θ Mucous in stools    θ Black or tarry stools    θ Chronic use of laxatives: what type of laxative?

Dampness trapped in body:

θ General sensation of heaviness in body    θ Mental heaviness    θ Mental sluggishness  
θ Mental fogginess    θ Swollen hands    θ Swollen feet    θ Swollen joints  
θ Chest congestion    θ Nausea    θ Snoring    θ Dizziness  
θ Snoring    θ Phlegm production

Stomach Function:

θ Burning sensation after eating    θ Large appetite    θ Bad breath    θ Vomiting  
θ Sores on lips, tongue or mouth    θ Ulcer (if diagnosed)    θ Belching    θ Acid regurgitation  
θ Cold sensation in stomach    θ Hiccoughs    θ Stomach Pain    θ Heartburn  
θ Bleeding, swollen or painful gums

Liver and Gallbladder Function:

θ Chest pains    θ Tight sensation in chest    θ Bitter taste in mouth  
θ Anger easily    θ Frustration    θ Depression  
θ Irritability    θ Skin rashes    θ Tingling sensations  
θ Numbness    θ Muscle Spasms    θ Muscle Twitching  
θ Muscle Cramping    θ Seizures    θ Convulsions  
θ Lump in throat    θ Teeth Grinding    θ Alternating diarrhea and

constipation  
 θ Neck tension                      θ Shoulder tension                      θ Hip pain/Sciatica  
 θ Drink alcohol                      θ Recreational drugs (which, how much per week?)  
 θ High pitch ringing in the ears                      θ Gallstones, history of or currently  
 θ Sexually transmitted diseases (which)                      θ Genital sores  
 θ Frequently unable to adapt to stress (what causes this stress?)  
 θ Headaches: How Often? Describe location:  
 θ Migraines

Eyes: (Liver Function)

θ Itchy                      θ Red or Bloodshot                      θ Hot                      θ Dry  
 θ Watery                      θ Gritty or sandy feeling                      θ Blurry vision                      θ Decreased night vision  
 θ Near-sighted                      θ Far-sighted                      θ Cataracts                      θ Visual Disturbances

Kidney, Urinary Bladder Function:

θ Frequent cavities                      θ Easily Broken Bones                      θ Poor hearing                      θ Earaches  
 θ Painful knees                      θ Weak knees                      θ Cold in knees                      θ Low back pain  
 θ Memory problems                      θ Excessive hair loss                      θ Pre-mature grey hair                      θ Low-pitch ringing in the ears  
 θ Kidney stones                      θ Bladder infections                      θ Fear                      θ Easily startled  
 θ Foot or ankle weakness or pain                      θ Lack bladder control                      θ Sneeze or jump incontinence

Urination:

How many times per day do you urinate?  
 Do you wake during the night to urinate?                      How many times per night?  
 θ Normal color urine                      θ Dark yellow                      θ Clear                      θ Reddish  
 θ Cloudy                      θ Scanty                      θ Profuse                      θ Strong Odor  
 θ Burning                      θ Painful                      θ Difficult                      θ Urgent

Libido:

θ Normal                      θ High                      θ Low

**Women only:**

Do you practice birth control?                      What type and for how long?  
 Pregnant?  θY θN                      Is there a chance you may be pregnant now?  
 Vaginal discharge:                      Frequent?                      Color?                      Odor?  
 Regular menstrual cycle?  θY θN  
 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: \_\_\_\_\_  
 Uterine bleeding/spotting between periods? θY θN                      How much and how often?

Do you experience any of the following pre-menstrual syndromes?

θ Nausea                      θ Vomiting                      θ Water retention                      θ Breast swelling  
 θ Food cravings                      θ Headaches                      θ Migraines                      θ Breast tenderness  
 θ Depression                      θ Irritability                      θ Anxiety                      θ Other emotions:  
 -----

θ Dull pain, where? \_\_\_\_\_

θ 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 (describ e size: large, small, black, purple, red, other)							
Vomitin g (check if yes)							
Nausea (check if yes)							
Other							

**Men only:**

θ Swollen testes  
ejaculation

θ Testicular pain

θ Impotence

θ Premature

θ Feeling of coldness or numbness in external genitalia

θ Other \_\_\_\_\_

**All please fill out:**

Please describe your Average Daily Diet:

Breakfast

Lunch

Dinner

Snacks (eaten at what time?):

Please tell us of any other problems you would like to discuss:

Patient Signature: \_\_\_\_\_

Acupuncturist Signature: \_\_\_\_\_