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: _(_____)_____

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. _____ 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:

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 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 timeof 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

Feelworse 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 feelingin 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 fogginess

Swollen hands

Swollen feet

Swollen joints

Chest congestion

Nausea

Snoring

Stomach function:

Burning sensation aftereating

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 ofthe head

Tingling sensation

Numbness

Muscle spasms

Muscle twitching

Muscle cramping

Seizures

Convulsions

Lump in the throat

Neck tension

Limited Rangeof-Motion, Neck

Shoulder tension

Limited Rangeof-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 inexternal genitalia Other_____

All please fill out:

Other Comments:_____

_____

Patient Signature:_____

Acupuncturist Signature:_____