Health History Questionnaire

Your patient records and patient information will be kept confidential and shared only when necessary to provide care and services, or by your authorization.

Patient Information

Full name:_____ Date:_____

Date of Birth:_____ Age:_____ Sex: _____ Email Address: _____

Occupation: _____ Physician:_____

Home Number: _____ Cell: _____

Address: _____ City: _____ State/Zip_____

Emergency Contact/Number: _____Relationship: _____

Have you had acupuncture before? Please circle Y/N. If so, what for?

_____

Who may we thank for referring you? _____

Health History

What are your primary reasons for seeking treatment in order of importance? Please include onset.

1. _____
2. _____
3. _____

Have you been given a diagnosis for this problem? If so, what_____

To what extent does this problem interfere with your daily activities? (work, sleep, sex, concentration, etc.)

_____

What type of treatment have you tried for this problem? _____

What makes it worse? _____ What makes it better? _____

How is your sleep? What time do you go to bed?_____

How is your digestion? _____ # of meals a day _____

Food allergies _____ # of bowel movements a week_____

Past Medical History

How long has it been since you had a complete medical exam? _____

Please circle any of the following that apply to you.

Cancer	Arthritis	Heart Disease
Diabetes	Restless Leg	Digestive Disorders
Hepatitis	Hypertension	HIV/AIDS
Thyroid Disease	Emotional Imbalance	Venereal Disease
Seizures	Anemia	
Fibromyalgia	Respiratory Problems	

Surgeries _____ Trauma/Accident_____

Allergies_____

Family medical history

Please circle all that apply to your blood relatives.

Diabetes Type I	Heart Disease	Schizophrenia
Diabetes Type II	Bone Disease	Severe Anxiety
Stroke	Celiac Disease	Eating Disorder
High Blood Pressure	Chrons Disease	ADHD
Obesity	Hypothyroidism	Autism
MS	Hyperthyroidism	HIV/AIDS
Cancer/Type_____	Major Depression	Alcoholism
Kidney Disease	Bipolar Disorder	Drug Abuse

Miscarriage

Are you living with any of the above conditions? _____

Please list any herbs, vitamins and supplements you are taking. _____

_____

Please circle any of the following medications you are currently taking.

Aspirin	Diet pills	Blood pressure pills
Antacids	Fiber	Antidepressants
Tylenol	Cold Tablets	Insulin
Ibuprofen	Sleeping Pills	Blood thinners
Laxatives	Tranquilizers	Other? _____
Allergy pills	Oral Contraceptives	

Do you smoke? Y/N What? _____ How many per day? _____ Since when? _____

Do you drink coffee/caffeine? Y/N How many cups per day_____

Do you drink alcohol? Y/N Average per week _____

Do you exercise? Y/N Are you on a special diet? _____

Please circle if you have had any of the following conditions in the last three to six months.

Pain –

1) Where applicable, please indicate Left (L) Right (R) or Both (B)
2) Using the pain scale of 1-10, with 1 being slight pain, please indicate the amount of pain.

Head	Elbow	Rib/flank	Thigh	Heel
Jaw	Forearm	Abdomen	Knee	Toes
Neck	Wrist	Upper back	Calf	
Throat	Hand	Mid-back	Shin	
Shoulder	Fingers	Low back	Ankle	
Upper arm	Chest	Hip	Foot	

Other related Symptoms_____

Musculoskeletal

Joint injury/swelling
Arthritis
Difficulty walking
Tremors
Cramps
Numbness
Muscle weakness
Tingling
Restless leg
Paralysis
Neck pain/tightness
Shoulder pain/tightness
Hip pain
Knee pain
Ankle pain/weakness
Hand/wrist pain
Muscle pain/soreness
Hands/feet swelling
Cold hands/feet
Back pain
Spinal curvature
Hernia

Other related Symptoms_____

Female Patients

Bleeding between periods
Excessive menstrual flow
Scanty menstrual flow
Endometriosis
Clots in menstrual blood
Extreme menstrual pain
Irregular cycle
Fibroids
Breast tenderness
Hot flashes
Moodiness related to periods
Breast lumps
Menopausal symptoms
PMS
Previous miscarriage
Could you be pregnant? Y/N
Age period started _____
Duration of period_____
Length of cycle (days)_____
Birth control? Y/N Type? ___
Pregnancies_____
Births _____
#Abortions_____

Other related Symptoms_____

Male Patients

Erection difficulties
Penis discharge
Prostate trouble

Other related Symptoms_____

LUNG SYSTEM

Frequent colds
Sinus infection
Cough
Cough with blood
Production of phlegm
Hay fever or allergies
Asthma
Bronchitis
Pneumonia
COPD
Acne
Rashes, hives, psoriasis
Often feel sadness
Crave spicy foods
Dry skin
Itching

Other related Symptoms_____

LIVER SYSTEM

Dry eyes
Red eyes
Eye inflammation
Blurred vision
Poor night vision
Irritability
Mental imbalance
Cataracts
Crave sour foods
Tendonitis
Insomnia
Excessive/vivid dreams
Grinding teeth
Depression
Anxiety/stress

Floaters in vision
Numbness or tingling of limbs
Poor concentration
Indecisiveness
Often feel angry
Gallstones
Migraine
Dizziness
Fainting
Seizures
Localized weakness
Visual changes
Glasses/contact lenses
Tremors
Paralysis
Aversion to wind

Other related Symptoms_____

STOMACH SYSTEM

Nausea/vomit
Belching
Heartburn
Bad breath
Bleeding gums
Ulcers
Excessive appetite
Nose bleeds
Difficulty swallowing
Recurring sore throat
Laryngitis/hoarse voice

Other related Symptoms_____

SPLEEN SYSTEM

Gas
Abdominal bloating
Abdominal pain
Decreased appetite
Indigestion
Low energy/fatigue
Crave sweets
Decreased taste/smell
Sweet taste in mouth
Often feel pensive
Edema
Diarrhea
Constipation
Blood in stools/black
Pus is stools
Hemorrhoids
Anal fissures
Rectal pain

Other related Symptoms_____

HEART SYSTEM

High blood pressure
Low blood pressure
Palpitations
Irregular heart beat
Chest pain or pressure
Jaw, neck, shoulder or arm pain
Nausea
Swollen hands or feet
Blood clotting disorder
Poor memory
Crave bitter foods

Other related Symptoms_____

KIDNEY SYSTEM

Frequent urination
Urgency to urinate
Pain on urination
Incontinence
Weak urine stream
Blood in urine
Kidney stones
Low back pain
Sore/weak knees
Crave salty foods
Often feel fear
Frequent urinary tract infections
Frequent vaginal infections
Pelvic inflammatory disease
Abnormal PAP
Irregular periods
PMS
Painful menstrual periods
Abnormal bleeding
Menopause symptoms

Breast lumps	Testicular lumps	Decreased libido
Ear infections	Prostatitis	Ear-ringing low pitch
Impotence	Genital itching/pain	Ear-ringing high pitch
Premature ejaculation	Genital lesion/discharge	Decreased hearing

Other related Symptoms_____

Please share any other problems/health issues not covered above that you would like to discuss.

_____

_____

I understand the above information and guarantee this form was completed correctly to the best of my knowledge. I will not hold my acupuncturist responsible for any errors or omissions that I may have made in the completion of this form.

Signature: _____ Date: _____