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.

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?_____

_____

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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 illness

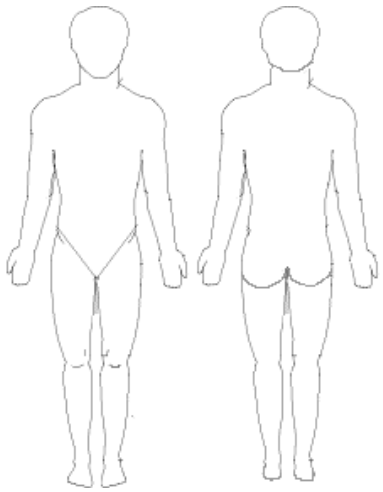
Other:

Immunizations:_____

Surgeries:_____

III. **Patient Profile**

After printing, please clearly mark any areas of pain and any scars:



Is the pain:

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

Does the following lessen the pain?

Pressure ☐	Cold ☐	Heat ☐	
Exercise ☐	Other:		

Does the following worsen the pain?

Pressure ☐	Cold ☐	Heat ☐	
Other:			

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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
- ☐ Night sweats
- ☐ Chest pain traveling to shoulder
- ☐ Frequent dreams
- ☐ Wake unrefreshed
- ☐ Drink Coffee (# of cups per week: _____)

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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
- ☐ Smoke cigarettes (# of cigarettes per day: _____)
- ☐ Overall achy feeling in the body
- ☐ Stiff neck
- ☐ Stiff shoulders
- ☐ Sore throat
- ☐ Difficulty breathing
- ☐ Sadness
- ☐ Melancholy
- ☐ Headache (Location: _____)
- ☐ Sneezing

Spleen function:

- ☐ Low appetite
- ☐ Abrupt weight gain
- ☐ 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

Spleen, Stomach, Large Intestine, Small Intestine function:

- ☐ Mucous in stools
- ☐ Undigested food in stools

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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

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Liver, Gall Bladder function:

- ☐ 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

Kidney, Urinary Bladder function:

- ☐ Lack of bladder control
- ☐ Fear
- ☐ Easily startled

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Urination:

- ☐ Normal color
- ☐ Dark yellow
- ☐ Clear
- ☐ Reddish
- ☐ Cloudy
- ☐ Scanty
- ☐ Profuse
- ☐ Strong odor
- ☐ Burning
- ☐ Painful
- ☐ Discharge
- ☐ Difficult
- ☐ Painful
- ☐ Urgent
- ☐ Frequent

Libido:

- ☐ Normal
- ☐ Low
- ☐ High

HEALTH HISTORY QUESTIONNAIRE

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							

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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:_____