HEALTH HISTORY QUESTIONNAIRE

Please take time to fill out this questionnaire as thoroughly. All information is kept confidential.

GENERAL INFORMATION

Name:		
Address:		
Home phone:	Work phone:	Cell phone:
Email address:		
May we add you to our clinic email list for newsletter, event, or promotion? Yes No		
What is the best way to reach you to protect your privacy?		
Age:	Date of birth:	Gender:
Height:	Weight:	Marital status:
Occupation:	Employer:	Family Physician:
Insurance company:		Policy#:
Emergency contact name, phone number, and relation to patient:		
How did you hear about our office?		

Main problem(s) or reason(s) for seeking treatment:
History of current problem (length, severity, level of interference in daily activities):
Western medical or other diagnosis:
Treatment that you have tried:

Past Medical History (significant illness, surgeries, trauma, falls, etc.):
Family Medical History (Please circle all applicable): Asthma Cancer Diabetes Heart Disease High Blood Pressure Seizures Stroke Thyroid Other (please specify):
Allergies (drug, food, environmental):

Current Medication/herbs/supplements	Dose per day	Duration	Reason

Please check if you have had any of these items listed below in the last 3 months.

Temperature (subjective sensation)

- □ Feeling hot/fever
- □ Feeling cold/chills
- □ Thirsty for hot/cold drinks
- □ Heat hands/feet/chest
- □ Cold hands, feet
- □ Perspire easily
- □ Hot flashes
- □ Alternating hot & cold
- □ Sweaty hands, feet
- □ Afternoon flashes
- □ Lack of perspiration
- □ Night sweats

Energy

- □ Normal
- □ Low
- □ High
- □ Fluctuates
- □ worse after exercise
- □ Difficulty keeping eyes open in the day time

General

- □ Weight loss/gain
- □ Poor sleeping
- □ Dental/gum problems
- □ Peculiar tastes/smells
- □ Bleed/Bruise easily
- □ Localized weakness
- □ Muscle weakness
- □ Poor balance
- □ Tremors
- □ Shortness of breath

Skin and Hair

- □ Rashes
- □ Ulcerations
- □ Fungal infection
- □ Itching
- □ Eczema/Psoriasis
- □ Dandruff
- □ Loss of hair
- □ Recent moles
- □ Skin discoloration
- □ Acne
- □ Change in hair/skin texture
- □ Dermatitis
- □ Warts
- □ Hives/Allergic Dermatitis

Head, Eyes, Ears, Nose and Throat

- □ Dizziness
- □ Eye strain
- □ Color blindness
- □ Ringing in ears
- □ Nose bleeds
- □ Recurrent sore throats / colds
- □ Difficulty swallowing
- □ Eye pain/itchiness
- □ Cataracts
- □ Poor hearing
- □ Sores on lips/tongue
- □ Dental problems
- □ Migraines
- □ Poor vision
- □ Blurred vision
- □ Spots in front of eyes
- □ Grinding teeth
- □ Jaw clicks/locks
- □ Headaches
- □ Night blindness
- □ Glasses
- □ Sinus problems
- □ Earaches
- □ Facial pain

Cardiovascular

- □ Chest pain or pressure
- □ Cold hands/feet
- □ Shortness of breath
- □ Spontaneous sweating
- □ Irregular heart beat
- □ Swelling of hands/feet
- □ Varicose /spider vein
- □ Palpitation at rest
- □ Blood clots
- □ High blood pressure
- □ Dizziness
- □ Phlebitis
- □ Low blood pressure

Respiratory

- □ Cough/Wheezing
- □ Pneumonia
- □ Difficulty breathing when lying down
- □ Coughing blood
- □ Production of phlegm
- □ Asthma
- □ Tight sensation in chest
- □ Pain with deep inhalation
- □ Bronchitis
- □ Difficult inhale/exhale

Gastrointestinal

- □ Nausea
- □ Gas
- □ Indigestion
- □ Bloating/Edema
- □ Change in appetite
- □ Cravings
- □ Vomiting
- □ Belching
- □ Bad breath
- □ Chronic laxative use
- □ Poor appetite
- □ Hernia
- □ Diarrhea
- □ Black stool
- □ Rectal pain
- □ Loose stool (>2 / day)
- □ Excessive appetite
- □ IBS/Crohn's disease
- □ Constipation
- □ Blood in stool
- □ Hemorrhoids
- □ Abdominal pain/Cramps
- □ Strong thirst
- □ Acid reflux/GERD

Genito-Urinary

- □ Pain on urination
- □ Unable to hold urine
- □ Impotence
- □ Premature ejaculation
- □ Nocturnal emission
- □ Night urination…
- □ Frequent urination
- □ Kidney stones
- □ Sores on genitals
- □ Decreased libido
- □ Pain in testicles
- How often?
- □ Blood in urine
- □ Scanty flow
- □ Urinary tract infection
- □ Prostatitis
- □ Herpes
- What time?
- □Urgent urination
- □Copious flow
- □Burning urination
- □Dribbling after urination
- □Infection

Gynecological/Reproductive

□ Painful intercourse □ Vaginal sores □ Vaginal dryness □ Vaginal discharge
□ Endometriosis □ Uterine Fibroids □ Ovarian cysts □ Infertility
□ Irregular menstruation □ Painful menstruation □ Fibrocystic breast tissue □ Pre-menstrual syndrome
□ Polycystic Ovarian Disease

□ Age of first menses: □ Date of last menses:
□ Number of pregnancies: □ Number of ectopic pregnancies:
□ Number of live births: □ Number of miscarriages:
□ Number of abortions: □ Are you pregnant? Y N
□ Do you practice birth control? Y N
What type? How long?
□ Average number of days of flow: □ Average number of days of entire cycle:
□ Uterine bleeding /spotting between periods? Y N How much? How often?

Please fill in the following menstrual chart.

	Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7
Color (normal, pale, bright red, brown, rust, dark, purple)							
Flow (normal, light, heavy)							
Pain/cramps (location, dull/sharp)							
Clots (small, big, color)							

Musculoskeletal

□ Neck pain □ Shoulder pain □ Hand/wrist pain □ Carpal Tunnel
□ Knee pain □ Sprain/Strains □ Sciatica □ Foot/ankle pain
□ Hip pain □ Muscle pain □ Muscle weakness □ Tendonitis
□ Back pain Low Middle Upper □ Bursitis □ Rotator cuff injury

Neuropsychological

□ Seizures □ Loss of balance □ Vertigo/Dizziness □ Areas of numbness
□ Lack of coordination □ Poor memory □ Concussion □ Depression
□ Anxiety/Panic attacks □ Bad temper/irritable □ Manic Depression □ Susceptibility to stress
□ Nervousness □ ADD/ADHD □ Seasonal Affective disorder
□ Have you ever been treated for emotional problems? Yes No
□ Have you ever considered or attempt suicide? Yes No
□ Have you ever been treated for substance abuse? Yes No

Diet

Meals per day: Snacks: Caffeinated drinks: Alcohol:
Your average daily diet:
Morning Afternoon Evening

Exercise
Frequency Length Type

Comments Please tell us any other problems you would like to discuss.

Patient Signature: _____.

Acupuncturist Signature: _____.