Health History Questionnaire

Please help us provide you with a complete evaluation by taking the time to fill out this questionnaire carefully. All of your answers will be held absolutely confidential. If you have questions, please ask If there is anything you wish to bring to our attention which is not asked on this form, please note it in the Comments section. Thank you.

Name: ____________________

Street: ____________________ City ____________ State ______ Zip ______

Age: ________ Height: ______ Weight: __________ Email ____________

Home Phone: ______________ Work Phone: ______________

Date/Place of Birth: ______________ Social Security Number: ______________

Occupation: ______________ Marital Status: ______________

In Emergency Notify: ____________________

Referred by: ____________________

Family Physician: ____________________

Insurance Carrier: ______________ Policy Number: ______________

Have you tried acupuncture or Chinese herbal medicine before? __________

Main problem(s) you would like to address: ____________________

____

To what extent does this problem affect your daily activities (work, sleep, eating, etc.)? ____

____

How long has it been since you first noticed any symptoms? ______________

Have you been given a diagnosis for the problem by your family physician? __________

If so, what is it? ____________________

What kinds of treatment have you tried? ____________________

Past medical history (please include dates):

- ☐ Allergies: ________
- ☐ Diabetes ________
- ☐ High Blood Pressure ________
- ☐ Seizures ________
- ☐ Surgeries ________
- ☐ Thyroid Disease: ________
- ☐ Cancer ________
- ☐ Hepatitis ________
- ☐ Heart disease ________
- ☐ Rheumatic Fever ________
- ☐ Venereal Disease ________
- ☐ Other significant illness (describe): ____________________
- ☐ Accidents or Significant Trauma (describe) ____________________

Birth History (prolonged labor, forceps delivery, etc): ____________________

Other relevant medical history: ____________________

____

____

____

FAMILY MEDICAL HISTORY:

- ☐ Allergies ______
- ☐ Diabetes ________
- ☐ Asthma ________
- ☐ Cancer ________
- ☐ Heart Disease ________
- ☐ High Blood Pressure
- ☐ Seizures ________
- ☐ Stroke ________
- ☐ Other________________________

OCCUPATION:____

Occupational stress factors (physical, psychological, chemical):________________________

____

LIFESTYLE:

Do you follow a regular exercise program? _______ If so, please describe: ______________

____

Please describe your average daily diet: ____

____

Please check any of the following habits that apply. Indicate how much and how often you consume them:____

☐ Cigarette smoking _____ ☐ Coffee, tea or cola _____ ☐ Alcoholic beverages _____

____

Medications taken within the last two months (vitamins, drugs, herbs, etc.): ____________

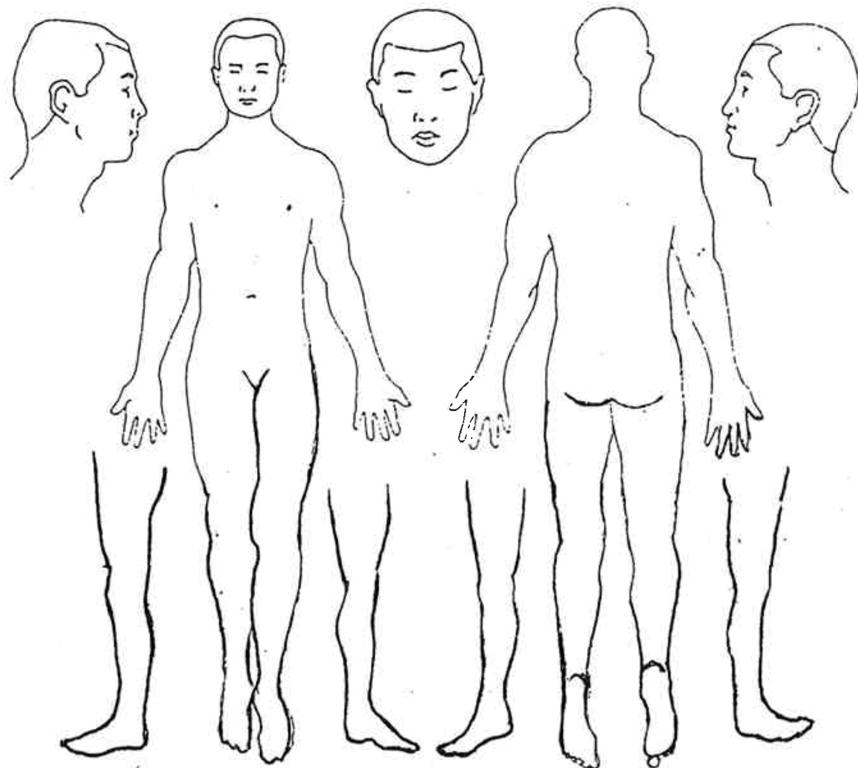
____

Please describe any use of drugs for non-medical purposes: ______________________

____

INDICATE PAINFUL OR DISTRESSED AREAS

Symbol	Reaction
Pain on pressure	
x	little
xx	moderate
xxx	strong
Swelling	
^	slight
^^	moderate
^^^	severe
Tension/weakness	
≉	weak
≈	tense
Spontaneous pain	
†	slight
††	moderate
†††	severe
Pulsing	
o	slight
oo	moderate
ooo	strong
Temperature	
−	colder
+	hotter
Physical	
⊗	sores
∇	rashes
⇒⇐	spasms



Please put a check next to conditions you have experienced within the last three months. Indicate the length of time you have had this condition:

General:

- ☐ Poor appetite ________ ☐ Insomnia ________ ☐ Disturbed sleep ________
- ☐ Localized weakness ________ ☐ Cravings ________ ☐ Strong thirst ________
- ☐ Weight gain ________ ☐ Weight loss ________ ☐ Changes in appetite________
- ☐ Sweating easily________ ☐ Tremors________ ☐ Bleeding or bruising easily ________
- ☐ Night Sweats ________ ☐ Fever ________ ☐ Chills________
- ☐ Sudden energy drop (time of day?) ________ ☐ Poor balance ________
- ☐ Other unusual or abnormal conditions you have noticed in your general sense of health?

____

Skin and hair

- ☐ Rashes ________ ☐ Ulcerations________ ☐ Hives ________
- ☐ Itching________ ☐ Eczema________ ☐ Pimples ________
- ☐ Dandruff________ ☐ Hair loss________ ☐ Recent moles ________
- ☐ Changes in hair or skin texture________

Any other hair or skin problems?____

Head, Eyes, Ears, Nose, Throat

- ☐ Dizziness ________ ☐ Concussions ________ ☐ Migraines________
- ☐ Glasses ________ ☐ Spots in front of eyes ________ ☐ Eye pain________
- ☐ Poor vision ________ ☐ Night blindness ________ ☐ Color blindness ________
- ☐ Cataracts ________ ☐ Blurry vision ________ ☐ Earaches ________
- ☐ Ringing in ears ________ ☐ Poor hearing ________ ☐ Eyestrain ________
- ☐ Sinus problems ________ ☐ Recurrent sore throats ________ ☐ Nose bleeds ________
- ☐ Grinding teeth ________ ☐ Sores on lips or tongue ________ ☐ Facial pain ________
- ☐ Teeth problems ________ ☐ Headaches (where? when?) ________ ☐ Jaw clicks ________

Any other head or neck problems? ____

Cardiovascular

- ☐ Dizziness ________ ☐ Low blood pressure ________ ☐ Chest pain ________
- ☐ Irregular heartbeat ________ ☐ High blood pressure ________ ☐ Fainting ________
- ☐ Cold hands or feet ________ ☐ Swelling of hands ________ ☐ Swelling of feet ________
- ☐ Blood clots ________ ☐ Difficulty in breathing ________ ☐ Phlebitis ________

Any other heart or blood vessel problems?____

Respiratory

- ☐ Cough ________ ☐ Coughing up blood ________ ☐ Asthma ________
- ☐ Bronchitis ________ ☐ Pain with deep inhalation ________ ☐ Pneumonia ________
- ☐ Difficulty breathing when lying down ________ ☐ Production of phlegm (color?) ________

Any other lung problems? ____

Gastrointestinal

☐ Nausea ______ ☐ Vomiting ______ ☐ Diarrhea ______
☐ Constipation ______ ☐ Gas ______ ☐ Belching ______
☐ Black stools ______ ☐ Blood in stools ______ ☐ Indigestion ______
☐ Bad breath ______ ☐ Rectal pain ______ ☐ Hemorrhoids ______
☐ Abdominal pain or cramps ______ ☐ Chronic laxative use ______

Any other problems with stomach or intestines? ______________________

Genito-urinary

☐ Pain on urination ______ ☐ Frequent urination ______ ☐ Blood in urine ______
☐ Urgency to urinate ______ ☐ Unable to hold urine ______ ☐ Kidney stones ______
☐ Decrease in flow ______ ☐ Impotence ______ ☐ Sores on genitals ______

Do you wake up at night to urinate?__________If so, how often? ______________

Any particular color to your urine? ______________________

Any other problems with your genital or urinary functions? ______________________

Reproductive and Gynecologic

☐ Menstrual clots ______ ☐ Painful menses ______ ☐ Unusual menses (heavy or light?) ______
☐ Changes in body/psyche prior to menstruation ______
☐ Irregular menses ______ ☐ Menopause (age?____) ☐ Other problems ______

Age at first menses ______ Length of time between menses ______ Duration ______

First day of last menses ______Number of pregnancies ______ Premature births ______

Miscarriages ______ Abortions ______ Number of births ______

Do you practice birth control? ______ If so, what type? ______ For how long? ______

Musculoskeletal

☐ Neck pain ______ ☐ Muscle pains ______ ☐ Knee pain ______
☐ Back pain ______ ☐ Muscle weakness ______ ☐ Foot/ankle pains ______
☐ Hand/wrist pains ______ ☐ Shoulder pains ______ ☐ Hip pain ______

Any other joint or bone problems? ______________________

Neuropsychological

☐ Seizures ______ ☐ Dizziness ______ ☐ Loss of balance ______
☐ Areas of numbness ______ ☐ Poor memory ______ ☐ Lack of coordination ______
☐ Concussion ______ ☐ Depression ______ ☐ Anxiety ______
☐ Bad temper ______ ☐ Easily susceptible to stress ______

Have you ever been treated for emotional problems?______________________

Have you ever considered or attempted suicide? ______________________

Any other neurological or psychological problems? ______________________

Comments

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

____