

Health History Questionnaire

Information for your Acupuncturist

Important: Complete this document as thoroughly as possible. Some of the questions may seem unrelated to your condition, but may play a major role in diagnosis and treatment.

All information is strictly confidential.

I. General Patient Information

Date: ___/___/___

Name: _____

Address: _____ City: _____

State: _____ Zip: _____ Home Phone: (____) _____

Work Phone: (____) _____ Cell: (____) _____

Email: _____

Date of Birth: ___/___/___ Age: _____ Place of Birth: _____

Marital Status: _____ Height: ___' ___" Weight: ___ lbs

Partner/Spouse: _____ Years married: _____

Children: _____

Pets: _____

Occupation: _____ Employer: _____

II. Medical History

Major Complaint(s) in order of significance to you:

	Severe	Moderate	Slight	
1.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
2.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
3.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
4.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

How do these conditions impair your daily activities? _____

What treatments have you tried for these conditions? _____

What result have you seen? _____

How was your childhood health? _____

Immunizations: _____

Surgeries/Hospitalizations: _____

Scars: _____

Trauma (physical or emotional): _____

Recent tests; (please indicate test results and date below)

Physical Cholesterol Other blood (which?) Prostate

HIV/STD Pap smear Mammography Other

Test Results and Date: _____

Check any you have had in the past:

- | | | |
|---|---|---|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Paralysis | <input type="checkbox"/> Glaucoma |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Stroke | <input type="checkbox"/> Lupus |
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Migraines | <input type="checkbox"/> Scleroderma |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Vein Condition | <input type="checkbox"/> Ulcerative Colitis |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Crohns Disease |
| <input type="checkbox"/> Thyroid Disorder | <input type="checkbox"/> Parkinsons | <input type="checkbox"/> Kidney Stones |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Gall Stones |
| <input type="checkbox"/> Hypertension | <input type="checkbox"/> Measles | <input type="checkbox"/> Other Neurologic disorder |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Mumps | <input type="checkbox"/> Other Hormone disorder |
| <input type="checkbox"/> Pancreatitis | <input type="checkbox"/> Mononucleosis | <input type="checkbox"/> Other kidney disorder |
| <input type="checkbox"/> Meningitis | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Other lung disorder |
| <input type="checkbox"/> HIV | <input type="checkbox"/> Polio | <input type="checkbox"/> Other liver disorder |
| <input type="checkbox"/> Syphilis | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Other pancreas/spleen disorder |
| <input type="checkbox"/> Gonorrhea | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Other: _____ |

III. Family History

	Age	Alive	Deceased	Health History
Father	____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Mother	____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Brother	____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Brother	____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Brother	____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Sister	____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Sister	____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Sister	____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Child	____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Child	____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Child	____	<input type="checkbox"/>	<input type="checkbox"/>	_____

IV. Patient Profile

Please mark any areas of pain or scars:

Is the pain:

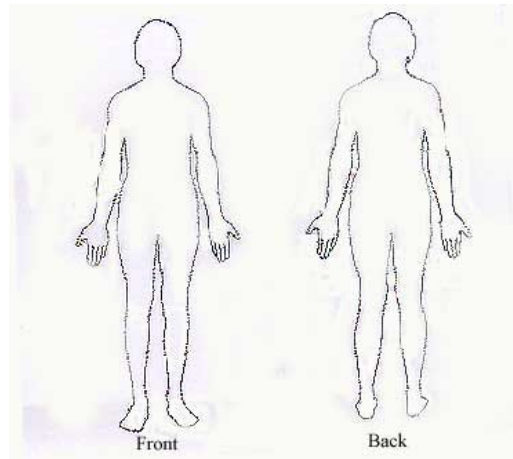
- Sharp Cramping Aching
 Dull Moving Tingling
 Burning Other: _____

Do the following lessen the pain?:

- Pressure Heat Cold
 Exercise Rest Other: _____

Do the following worsen the pain?:

- Pressure Heat Cold
 Exercise Rest Other: _____



Overall Energy (Lung, Kidney function):

- Fatigue during the day
 General weakness
 Easily catch colds
 Shortness of breath
 Feel worse after exercise
 Prolonged recovery from illness
 Aversion to talking
 Pasty pale complexion
 Exercise: What? _____ How Often? _____

Overall Temperature (Kidney function):

- Cold hands/feet
 Sweaty hands/feet
 Feel generally more Hot
 Feel generally more Cold
 Afternoon flushes
 Red cheeks at times
 Hot flashes any time of day
 Night sweats
 Heat in hands, feet, and chest
 Thirsty and drink in gulps
 Thirst but no desire to drink
 Thirst but take sips
 Take water to bed
 Perspire easily – where? _____
 Perspire w/ rest
 Lack of perspiration

Heart function:

- Palpitations
 Anxiety
 Panic attacks
 Emotional Sensitivity
 Restlessness
 Easily startled
 Trouble falling asleep
 Dull or glazed eyes
 Chest pain or discomfort
 Sores on tip of tongue
 Frequent dreams
 Ever fainted

Lung function:

- Nasal discharge (Color: _____)
 Sinus congestion
 Allergies (To: _____)
 Nose bleeds
 Dry cough
 Productive cough (Color: _____)
 Dry mouth, nose, throat, skin
 Sore throat
 Overall achy feeling
 Alternating chills & fever
 Trouble breathing
 Asthma – trouble w/exhaling
 Sadness, melancholy, grief

Spleen function:

- Low appetite
- Abrupt weight gain
- Abrupt weight loss
- Abdominal bloating
- Abdominal gas
- Gurgling noise in stomach
- Fatigue after eating
- Prolapsed organs (bladder, vagina)
- Hernias
- Hemorrhoids
- Easily bruised
- Pensive
- Over-thinking, obsess
- Worry
- Difficulty focusing, distractible
- Overwhelmed by details

Large and Small Intestine function:

- Bowel movement: (#/day ____, or #/wk ____)
- Loose
- Diarrhea
- Burning
- Lack of control (incontinence)
- Constipation
- Hard dry stool
- Incomplete
- Blood in stool
- Mucous in stool
- Undigested food in stool
- Cramping and pain
- Gas/flatus
- Blood sugar variable
- Food sensitivity / intolerance: _____

Dampness trapped in the body:

- General sensation of heaviness
- Mental heaviness, sluggishness, fogginess
- Swollen hands, feet, joints
- Chest congestion
- Sinus congestion
- Nausea
- Snoring

Stomach function:

- Large appetite
- Mouth (canker) sores
- Bad breath
- Bleeding, swollen or painful gums
- Burning sensation after eating
- Heartburn, acid regurg, GERD
- Ulcer (diagnosed in past)
- Belching
- Hiccoughs
- Stomach pain
- Nausea/Vomiting
- Anorexia
- Bulimia
- Headache over forehead
- Aversion to strong odors or flavors

Liver/Gall Bladder function:

- Alternating diarrhea / constipation
- Tight sensation in chest or under ribs
- Bitter taste in mouth
- Lump in throat / trouble swallowing
- Itching
- Skin rashes
- Muscle spasm, twitching, cramping
- Tingling sensation
- Numbness
- Migraines
- Headaches on top or side of head
- Neck and shoulder tension
- Seizures or stroke
- Alcohol (# drinks ___ /day / week / month)
- Recreational drug history or current use
What: _____
How often: _____
- Smoke (# cigs ___ packs ___ / day /wk)
started ___ (yr) quit ___ (yr)
- Medications: (Name, dosage, for what)

Liver function (cont'd):

- Eyes bloodshot, hot, dry, painful, gritty
- Watery eyes
- Discharge from eyes
- Conjunctivitis
- Blurred vision
- Decreased night vision
- Cataracts
- Macular degeneration
- Glasses (what age: _____)
- Anger easily
- Frustration, irritability
- Depression
- Unable to adapt to stress
- PMS
- High pitched ringing in ears

Kidney and Bladder function:

- Kidney stones
- Urinary tract infections (UTI)
- Wake during the night to void
- Low back pain
- Cold knees
- Weak, sore knees
- Frequent cavities
- Broken bones
- Memory problems
- Excess hair loss
- Early graying of hair
- Decreased range of motion
- Repeat miscarriage
- Need excessive sleep
- Apathy or decreased motivation
- Easily defeated or disgruntled
- Dark circles under eyes
- Asthma trouble w/ inhaling
- Phobia or fears
- Low pitched ringing in ears
- Hearing loss or trouble hearing
- Urgency or frequent urination
- Difficult or incomplete urination
- Lack of bladder control
- Stress incontinence
- Crave caffeine & stimulants
- #cups coffee/day___ or week___
- Water intake: #glasses/day_____

Sexual function:

- Normal libido
- High libido
- Low libido
- Difficulty with arousal or climax

Men only:

- Premature ejaculation
- Impotence
- Swollen testicles
- Testicular pain
- Feeling of coldness in genitals
- Prostate swelling or prostatitis
- Elevated PSH

Blood (liver, spleen, heart function):

- Dizziness, light headed
- See floating spots
- Weak vision
- Dry eyes, hair, nails, skin
- Dry mucous membranes
- Thin hair
- Pale sallow complexion
- Restless fatigue
- Anxious sleep
- Emotional sensitivity
- Itchy skin
- Muscle cramps
- Dry hard stool
- Anemia
- Infertility
- Lack of semen
- Miscarriage history
- Lack of breast milk
- Postpartum weakness
- Postpartum depression
- Poor skin healing
- Decrease flexibility
- Poor concentration

Women only:

Regular menses? Y N

Pregnant? Y N

Number pregnancies: _____

Number miscarriages/abortions: _____

Age of first menses: _____

Number of Days of flow: _____

Number of Days of entire cycle: _____

Bleeding between periods

Endometriosis Ovarian Cysts

Complications with pregnancies: _____

Birth Control method: _____

Do you have any of these PMS symptoms

Nausea Vomiting Food cravings

Headaches Migraines Bloating

Breast tenderness Breast swelling

Irritability Depression Anxiety

Cramping Other: _____

Vaginal discharge: (Color: _____)

Fibroids

Vaginal delivery (#: _____) C-sections (#: _____) Breastfed

Postpartum complications: _____

Please fill in the following menstrual chart:

	Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7
Color (red, bright, pale, brown, rust, purple)							
Amount (heavy, mod, light, spotting)							
Pain/cramps (dull, sharp)							
Clots (lrg, sml, red, black)							
Vomiting (V), Nausea (N)							
Headache or Migraine							
Other							

Other comments: _____

Patient signature: _____