Health History Questionnaire

Please help us provide you with a complete evaluation by taking 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 on the "Comments" section. Thank you.

Date: __/__/____

NAME: _____
FIRST LAST

EMAIL: _____

HOME PHONE: _____ WORK PHONE:_____

ADDRESS:_____
STREET CITY STATE ZIP

DATE OF BIRTH: ____/____/_____ AGE:_____ HEIGHT: _____ WEIGHT: _____

OCCUPATION: _____ FAMILY PHYSICIAN:_____

REFERRED BY:_____

MEDICAL INSURANCE: _____ ID: _____

SUBSCRIBER NAME: _____ PHONE (Ins.):_____

EMERGENCY CONTACT: _____
NAME PHONE NUMBER

RELATION TO YOU:_____

- HAVE YOU TREATED BY ACUPUNCTURE OR ORIENTAL MEDICINE BEFORE?
  (CHECK ONE) YES____ NO_____

- MAIN PROBLEM(S) YOU WOULD LIKE US TO HELP YOU WITH:

_____
_____
_____
_____

- TO WHAT EXTENT DOES THIS PROBLEM INTERFERE WITH YOUR DAILY ACTIVITIES SUCH AS WORK, SLEEP, AND SEX?

_____
_____
_____

- HAVE YOU BEEN GIVIEN A DIAGNOSIS FOR THIS PROBLEM? IF SO, WHAT IS IT?

_____
_____
_____

- WHAT OTHER KINDS OF TREATMENTS HAVE YOU TRIED?

_____
_____
_____

Past Medical History: (Please include date)

SIGNIFICANT ILLNESS (please circle all applicable)

- ❑ CANCER
- ❑ DIABETES
- ❑ HEPATITIS
- ❑ HIGH BLOOD PRESSURE
- ❑ HEART DISEASE
- ❑ RHEUMATIC FEVER
- ❑ THYROID DISEASE
- ❑ SEIZURES
- ❑ VENEREAL DISEASE
- ❑ OTHER (PLEASE SPECIFY)_____

SURGERIES:_____
_____
_____

SIGNIFICANT TRAUMA (AUTO ACCIDENTS, FALLS, ETC):_____
_____
_____

ALLERGIES:
_____
_____
_____

FAMILY MEDICAL HISTORY (PLEASE CHECK ALL APPLICABLE):

- ❑ ASTHMA
- ❑ ALLERGIES
- ❑ DIABETES
- ❑ CANCER
- ❑ HEART DISEASE
- ❑ HIGH BLOOD PRESSURE
- ❑ STROKE
- ❑ SEIZURE
- ❑ THYROID
- ❑ OTHER (PLEASE SPECIFY):_____

MEDICINES TAKEN WITHIN THE LAST TWO MONTHS (VITAMINS, DRUGS, HERBS, ETC.)
_____
_____
_____

OCCUPATIONAL STRESS (CHEMICAL, PHYSICAL, PSYCHOLOGICAL, ETC.)
_____
_____
_____

DO YOU HAVE A REGULAR EXERCISE PROGRAM? IF YES, PLEASE DESCRIBE.
_____
_____
_____

HAVE YOU EVER BEEN ON A RESTRICTED DIET? IF YES, WHAT KIND?
_____
_____
_____

DO YOU CRAVE CERTAIN FOOD?
_____
DO CERTAIN FOOD "DISAGREE" WITH YOU?
_____

PLEASE DESCRIBE YOUR AVERAGE DAILY FOOD INTAKE:

MORNING: _____

AFTERNOON: _____

EVENING: _____

DO YOU SMOKE? IF YES HOW MUCH?

_____

HOW MUCH CAFFEINATED COFFEE, TEA, OR COLA DO YOU DRINK PER WEEK?

_____

HOW MUCH WATER DO YOU DRINK DAILY?

_____

HOW MUCH ALCOHOL DO YOU DRINK?

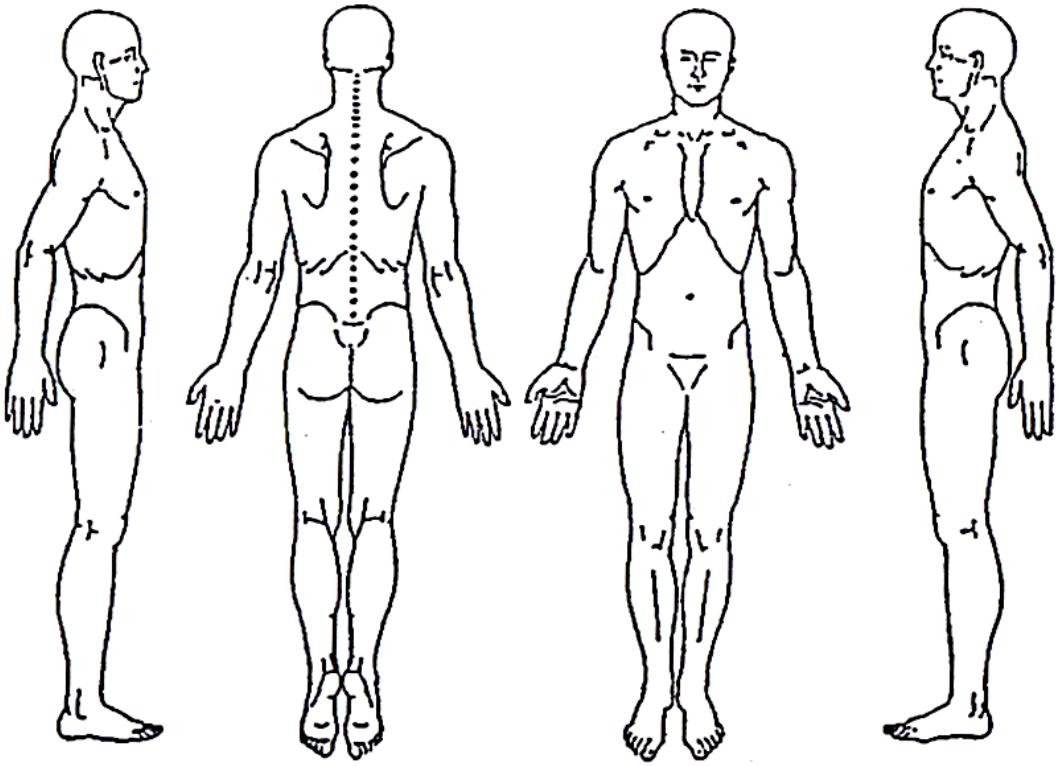
_____

PLEASE DESCRIBE ANY USE OF DRUGS FOR NON-MEDICAL PURPOSES:

_____

_____

PLEASE INDICATE ANY PAINFUL OR DISTRESSED AREAS BY CIRCLING THE AREA:



PLEASE CHECK ALL YOU HAVE HAD IN THE LAST THREE MONTHS:

GENERAL

- ❑ FEVERS
- ❑ SWEATS EASILY
- ❑ NIGHT SWEATS
- ❑ CHILLS
- ❑ BLEED OR BRUISE EASILY
- ❑ PECULIER TASTES OR SMELLS
- ❑ CRAVINGS
- ❑ CHANGE IN APPETITE
- ❑ WEIGHTLOSS
- ❑ WEIGHT GAIN
- ❑ STRONG THIRST (HOT OR COLD DRINKS)
- ❑ POOR SLEEP
- ❑ FATIGUE
- ❑ SUDDEN ENGERY DROP (TIME OF DAY?)

SKIN & HAIR

- ❑ RASHES
- ❑ ITCHING
- ❑ DANDRUFF
- ❑ CHANGE IN HAIR OR SKIN TEXTURE
- ❑ ULCERATIONS
- ❑ ECZEMA
- ❑ LOSS OF HAIR
- ❑ HIVES
- ❑ PIMPLES
- ❑ RECENT MOLES
- ❑ ANY OTHER HAIR OR SKIN PROBLEM

HEAD, EYES, EARS, NOSE, AND THROAT

- ❑ DIZZINESS
- ❑ GLASSES
- ❑ POOR VISION
- ❑ CATARACTS
- ❑ RINGING IN EARS
- ❑ SINUS PROBLEMS
- ❑ GRINDING TEETH
- ❑ TEETH PROBLEMS
- ❑ CONCUSSIONS
- ❑ EYE STRAIN
- ❑ NIGHT BLINDNESS
- ❑ BLURRY VISION
- ❑ POOR HEARING
- ❑ NOSE BLEEDS
- ❑ FACIAL PAIN
- ❑ JAW CLICKS
- ❑ MIGRAINES
- ❑ EYE PAIN
- ❑ COLOR BLINDNESS
- ❑ EARACHES
- ❑ SPOTS IN FRONT OF EYES
- ❑ RECURRENT SORE THROATS
- ❑ SORES ON LIPS OR TONGUE
- ❑ HEADACHES (WHERE, WHEN?)
- ❑ ANY OTHER HEAD OR NECK PROBLEMS?

CARDIOVASCULAR

- ❑ CHEST PAIN
- ❑ IRREGULAR HEARTBEAT
- ❑ HIGH BLOOD PRESSURE
- ❑ LOW BLOOD PRESSURE
- ❑ FAINTING
- ❑ COLD HAND OR FEET
- ❑ SWELLING OF FEET
- ❑ SWELLING OF HANDS
- ❑ BLOOD CLOTS
- ❑ PHLEBITIS
- ❑ PERIPHERAL ARTERIAL SCLEROSIS
- ❑ VARICOSE VEINS

RESPIRATORY

- ❑ COUGH
- ❑ COUGHING BLOOD
- ❑ BRONCHITIS
- ❑ PNEUMONIA
- ❑ PRODUCTION OF PHLEGM (WHAT COLOR)
- ❑ ASTHMA
- ❑ DIFFICULTY BREATHING
- ❑ WHEEZING WHILE BREATHING
- ❑ DIFFICULTY BREATHING WHEN LYING DOWN
- ❑ SHORTNESS OF BREATH
- ❑ PAIN WITH A DEEP BREATH
- ❑ ANY OTHER LUNG/ BREATHING PROBLEMS?

GASTROINTESTINAL

- ❑ NAUSEA
- ❑ VOMITTING
- ❑ INDIGESTION
- ❑ GAS
- ❑ BELCHING
- ❑ DIARRHEA
- ❑ CONSTIPATION
- ❑ BLOOD IN STOOLS
- ❑ BLACK STOOLS
- ❑ CHRONIC LAXATIVE USE
- ❑ ABDOMINAL PAIN OR CRAMPS
- ❑ RECTAL PAIN
- ❑ HEMORRHOIDS
- ❑ BAD BREATH
- ❑ BLEEDING GUMS
- ❑ ANY OTHER PROBLEMS WITH STOMACH OR INTESTINES?

URINARY

- ❑ FREQUENT URINATION
- ❑ URGENCY TO URINATE
- ❑ UNABLE TO HOLD URINE
- ❑ PAIN UPON URINATION
- ❑ BLOOD IN URINE
- ❑ DECREASE IN FLOW
- ❑ KIDNEY STONES
- ❑ ANY PARTICULAR COLOR OF URINE:
- ❑ DO YOU WAKE UP TO URINATE? HOW OFTEN?
- ❑ ANY OTHER PROBLEMS WITH YOUR URINARY SYSTEM?

MALE REPRODUCTIVE:

- ❑ IMPOTENCE
- ❑ PROSTATITIS
- ❑ PROSTATE CANCER
- ❑ BENIGN PROSTATIC HYPERTROPHY
- ❑ PREMATURE EJACULATION
- ❑ SPERMATORRHEA
- ❑ LOW SPERM COUNT
- ❑ LOW MOTILITY
- ❑ TESTICULAR PAIN/INJURY
- ❑ TESTICULAR CANCER
- ❑ SORES ON GENITALS
- ❑ STD'S
- ❑ ANY OTHER REPRODUCTIVE PROBLEMS?

FEMALE REPRODUCTIVE:

- ❑ AGE OF FIRST MENSES:_____
- ❑ REGULAR MENSTRUAL CYCLE
- ❑ IRREGULAR MENSTRUAL CYCLE
- ❑ MENSTRUAL CYCLE RANGE: _____
- ❑ PAINFUL PERIODS
- ❑ UNUSUAL CHARACTER (HEAVY/LIGHT)
- ❑ CLOTS
- ❑ PMS SYMPTOMS:_____
- ❑ BIRTH CONTROL/DURATION OF USE _____
- ❑ LAST MENSTRUAL PERIOD DATE _____
- ❑ CURRENTLY PREGNANT
- ❑ PREGNANCIES #:_____
- ❑ LIVE BIRTHS #: _____
- ❑ MISCARRIAGE #:_____
- ❑ ABORTION #:_____
- ❑ MENOPAUSE AGE:_____
- ❑ UNUSUAL VAGINAL DISCHARGE
- ❑ BREAST LUMPS
- ❑ STDs
- ❑ ANY OTHER REPRODUCTIVE PROBLEMS?

MUSCULOSKELETAL

- ❑ NECK PAIN
- ❑ SHOULDER PAIN
- ❑ BACK PAIN
- ❑ HAND/WRIST PAIN
- ❑ HIP PAIN
- ❑ KNEE PAIN
- ❑ FOOT/ANKLE PAIN
- ❑ MUSCLE PAIN
- ❑ MUSCLE WEAKNESS
- ❑ ANY OTHER MUSCLE, JOINT OR BONE PROBLEMS?

NEUROLOGICAL

- ❑ SEIZURES
- ❑ STOKE
- ❑ CONCUSSION
- ❑ DIZZINESS
- ❑ LOSS OF BALANCE
- ❑ LACK OF COORDINATION
- ❑ AREAS OF NUMBESS
- ❑ POOR MEMORY
- ❑ TREMORS (WHERE?)

PSYCHOLOGICAL

- ❑ DEPRESSION
- ❑ ANXIETY
- ❑ FEARFUL

- ❑ EASILY ANGERED
- ❑ EASILY SUSCEPTIBLE TO STRESS
- ❑ EASILY OVER WORRIED
- ❑ SADNESS
- ❑ OVERLY JOYFUL
- ❑ ANY OTHER NEUROLOGICAL OR PSYCHOLOGICAL PROBLEMS?

❖ HAVE YOU EVER BEEN TREATED FOR EMOTIONAL PROBLEMS?_____
_____

❖ HAVE YOU EVER CONSIDERED OR STTEMPTED SUICIDE? _____
_____

COMMENTS:

PLEASE BRIEFLY TELL US OF ANY OTHER PROBLEMS YOU WOULD LIKE TO DISCUSS.
_____
_____
_____
_____
_____

END OF QUESTIONAIRE