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Health History Questionnaire

Date: ___/___/___

Name:	**Home Phone:**	**Work Phone:**	**Mobile Phone:**

Address:	**City:**	**State:**	**Zip Code:**

Email:	**Sex:** ☐ Male ☐ Female	**Age:**	**Date of Birth:**	**Height:**	**Weight:**

Marital Status (check one):	**Employer Name:**
☐ Never Married ☐ Living with Partner ☐ Married ☐ Divorced ☐ Separated ☐ Widowed	**Occupation:**

In Emergency, Contact (Name):	**Emergency Contact Phone:** **Day** **Evening**

Have you been treated by acupuncture or oriental medicine before? ☐ Yes ☐ No	**Referred By:**

What is/are the main problem(s) you would like us to help you with today? _____

_____

_____

When did this problem begin? (Please be specific) _____

_____

Was there a known cause/instigating factor for your problem? _____

_____

What treatments have you tried already? What were the results? _____

_____

_____

Have you been given a diagnosis for this problem? If so, what? _____

_____

To what extent does this problem interfere with your daily activities? (work, sleep, eating, sex...) _____

_____

_____

How severe is your problem right now? (Please mark the scale below)

No problem Moderate Worst Imaginable

What's the most severe level you have endured within the last week? (Please mark the scale below)

No problem Moderate Worst Imaginable

Patient Name: _____ Date: _____

Past Medical History (please indicate by date(s):

Cancer _____	High Blood Pressure _____	Rheumatic Fever _____	Venereal Disease _____
Diabetes _____	Heart Disease _____	Seizures _____	Asthma _____
Hepatitis _____	Stroke _____	Thyroid Disease _____	Pacemaker _____
Other: _____			

Surgeries (type and date): _____

_____

Significant Trauma (auto accidents, falls, etc.): _____

_____

Significant Dental Work (type and date): _____

_____

Birth History (prolonged labor, forceps delivery, caesarian section, other): _____

_____

Allergies (drugs, chemicals, foods, animals): _____

_____

Family Medical History (check):

☐ High Blood Pressure	☐ Alcoholism	☐ Cancer:	☐ Allergies:
☐ Heart Disease	☐ Seizures	(type)_____	_____
☐ Arteriosclerosis	☐ Asthma	_____	_____
☐ Stroke	☐ Diabetes	☐ Other_____	

Occupational Stress (chemical, physical, psychological, etc.): _____

_____

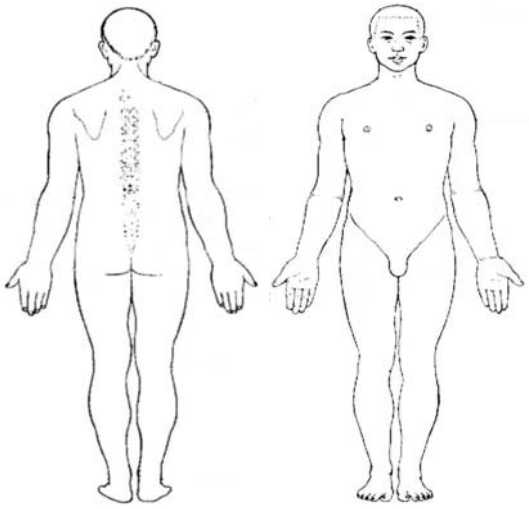
Do you exercise regularly? Yes No Please describe: _____

_____

Comments (please list any other problems you would like to discuss): _____

_____

Indicate Painful or Distressed Areas



What are Your Treatment Goals?

- ☐ Temporary relief of symptoms/pain control
- ☐ Eliminate root or cause of problem (if possible)
- ☐ Lessen/eliminate habits which caused the condition or made it worse
- ☐ Maintenance care (periodic balancing/tune-up to keep in good health)

Patient Name: _____ Date: _____

Please check any boxes of symptoms you have had in the past 3 months.

General

- ☐ Chills
- ☐ Fevers
- ☐ Sweat easily
- ☐ Night sweats
- ☐ Localized weakness
- ☐ Bleed or bruise easily
- ☐ Peculiar tastes or smells
- ☐ Strong thirst (cold / hot)
- ☐ Thirst, no desire to drink
- ☐ Fatigue
- ☐ Sudden energy drop
  *Time of day:*_____
- ☐ Edema
  *Where:*_____
- ☐ Poor sleeping
- ☐ Tremors
- ☐ Poor balance
- ☐ Cravings
- ☐ Change in appetite
- ☐ Poor appetite
- ☐ Weight change
  Gain / Loss _____

Skin and Hair

- ☐ Rashes
- ☐ Itching
- ☐ Change in hair or skin
- ☐ Ulcerations
- ☐ Eczema
- ☐ Oozing skin lesion
- ☐ Hives
- ☐ Pimples
- ☐ Recent moles
- ☐ Loss of hair
- ☐ Dandruff

Other hair or skin problems

_____

_____

Head, Eyes, Ears Nose, and Throat

- ☐ Dizziness
- ☐ Migraines
- ☐ Headaches
  *When:*_____
  Where: _____
- ☐ Facial pain
- ☐ Glasses
- ☐ Poor vision
- ☐ Night blindness
- ☐ Blurry vision
- ☐ Color blindness
- ☐ Blind field
- ☐ Spots in front of eyes
- ☐ Eye pain
- ☐ Eye strain
- ☐ Cataracts
- ☐ Eye Dryness
- ☐ Excessive tearing
- ☐ Discharge from eyes
- ☐ Poor hearing
- ☐ Ringing in ears
- ☐ Earaches
- ☐ Discharge from ear
- ☐ Nose bleeds
- ☐ Sinus congestion
- ☐ Nasal drainage
- ☐ Grinding teeth
- ☐ Teeth problems
- ☐ Jaw clicks
- ☐ Concussions
- ☐ Recurrent sore throats
- ☐ Hoarseness
- ☐ Sores on lips/tongue

Other head / neck problems

Cardiovascular

- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Chest discomfort/pain
- ☐ Heart palpitations
- ☐ Cold hands or feet
- ☐ Swelling of hands
- ☐ Swelling of feet
- ☐ Blood clots
- ☐ Fainting
- ☐ Difficulty in breathing

Other heart/blood vessel problems: _____

Respiratory

- ☐ Cough
- ☐ Asthma/wheezing
- ☐ Difficulty in breathing when lying down
- ☐ Phlegm *Color?*_____
- ☐ Coughing blood
- ☐ Pneumonia
- ☐ Bronchitis

*Other lung problems:*_____

_____

Gastrointestinal

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

*Other stomach or intestinal problems:*_____

_____

Genito-Urinary

- ☐ Pain on urination
- ☐ Urgency to urinate
- ☐ Frequent urination
- ☐ Blood in urine
- ☐ Decrease in flow
- ☐ Dribbling
- ☐ Kidney stones
- ☐ Impotency
- ☐ Change of sexual drive
- ☐ Sores on genitals

Do you wake to urinate?
☐ Yes ☐ No

How often? _____

What color is your urine?

_____

*Other genital or urinary system problems?*_____

_____

Pregnancy and Gynecology

of pregnancies: _____
# of births: _____
premature births: _____
of miscarriages: _____
# of abortions: _____
Age at first menses: _____
Length of full cycle: _____
Length of menses: _____
Last menses start date: _____

- ☐ Heavy periods
- ☐ Light periods
- ☐ Painful periods
- ☐ Irregular periods
- ☐ Changes in body/psyche prior to menstruation
- ☐ Clots
- ☐ Vaginal discharge:
- ☐ Menopause:
  Age: _____
  *Year:*_____
- ☐ Postcoital bleeding
- ☐ Vaginal sores
- ☐ Breast lumps
- ☐ Nipple discharge

Do you practice birth control?
☐ Yes ☐ No

What type and for how long?

_____

Musculoskeletal

- ☐ Neck pain
- ☐ Shoulder pain
- ☐ Back pain
- ☐ Elbow pain
- ☐ Hand/wrist pain
- ☐ Hip pain
- ☐ Knee pain
- ☐ Foot/ankle pain
- ☐ Muscle pain
- ☐ Muscle weakness

Other pain? _____

_____

Neuropsychological

- ☐ Seizures
- ☐ Areas of numbness
- ☐ Weakness
- ☐ Sleep disorder
- ☐ Concussion
- ☐ Violence potential
- ☐ Vertigo
- ☐ Lack of coordination
- ☐ Bad temper
- ☐ Depression
- ☐ Easily stressed
- ☐ Loss of balance
- ☐ Poor memory
- ☐ Anxiety
- ☐ Substance abuse

Have you ever been treated for emotional problems?
☐ Yes ☐ No

Patient Name: _____ Date: _____

Last Physical

Date: _____ Doctor: _____ Results: _____

Habits

Please indicate below: None, Light, Moderate, or Heavy. Please add comments where significant

	Excessive	Moderate	Minimal	None	
Alcohol:	☐	☐	☐	☐	
Coffee:	☐	☐	☐	☐	
Tea:	☐	☐	☐	☐	
Tobacco:	☐	☐	☐	☐	
Exercise:	☐	☐	☐	☐	
Sleep:	☐	☐	☐	☐	
Appetite:	☐	☐	☐	☐	
Energy Level:	☐	☐	☐	☐	
Medication:	☐	☐	☐	☐	
Vitamins:	☐	☐	☐	☐	
Food Intake:	☐	☐	☐	☐	
Teeth problems:	☐	☐	☐	☐	
Drugs:	☐	☐	☐	☐	
Salt Intake:	☐	☐	☐	☐	
Other:	☐	☐	☐	☐	
Stress Level:	☐	☐	☐	☐	

Diet

Please give a general description of the food you eat during a "typical" day.

Morning: .....

.....

Afternoon: .....

.....

Evening: .....

.....

Before bed: .....

Between meals: .....

Are you now, or have you ever been, on a restricted diet? Please describe the diet and give the start/stop dates:

_____

_____

What allergies do you have? What reactions do you have to these chemicals, foods, etc?

_____

_____

Patient Name: _____ Date: _____

Current Medications (past 2 months)

Medication	Dose	Frequency	Start Date (mm/yy)	Reason For Use

Nutritional Supplements (Vitamins/Minerals/Herbs/Homeopathy)

Supplication and Brand	Dose	Frequency	Start Date (mm/yy)	Reason For Use

Have your medications or supplements ever caused you unusual side effects or problems? Yes No

Please describe: _____

_____

Have you had prolonged or regular use of NSAIDS (Advil, Aleve, etc.), Motrin, Aspirin, Tylenol, Acid Blocking Drugs (Tagamet, Zantac, Prilosec, etc.)? Yes No

Frequent antibiotics more than 3 times in a year? Yes No

Long term antibiotics? Yes No

Use of steroids (prednisone, nasal allergy inhalers) in the past? Yes No

Use of oral contraceptives? Yes No