**HEALTH HISTORY QUESTIONNAIRE**
Information for your Acupuncturist

*Important:* Complete this document as thoroughly as possible. Some of the questions that follow may seem unrelated to your condition, but they may play a major role in diagnosis and treatment. *All information is strictly confidential.*

## I. General Patient Information

Date: ____/____/____ Email Address: _____

Name: _____

Address: _____

City, State, Postal Code: _____

Home Phone: _(_____)_____ Work Phone: _(_____)_____

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

Guardian (if under 18): _____

Gender: ☐ M ☐ F Height: ____'____" Weight: _____lbs.

Social Security Number: _____-_____-_____ Driver's License #: _____

Occupation:_____Employer:_____

How did you hear about our office? _____

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

1. _____ 4. _____
2. _____ 5. _____
3. _____ Additional:_____

How do these conditions impair your daily activities?_____

_____

## II. Patient Medical History

How was your childhood health?_____

Hospital Visits/Stays:_____

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

☐ Physical ☐ Cholesterol ☐ Prostate ☐ Blood (which?)
☐ HIV/STD ☐ Pap smear ☐ Mammography ☐
Other:_____

Test Results and Date:_____

Check any you have had in the past:

| | | | |
|---|---|---|---|
| ☐ Diabetes | ☐ Allergies | ☐ Glaucoma | ☐ Rheumatic Fever |
| ☐ Heart Disease | ☐ CVA (stroke) | ☐ Vein condition | ☐ Thyroid disorder |
| ☐ Asthma | ☐ Pneumonia | ☐ Tuberculosis | ☐ Emphysema |
| ☐ Jaundice | ☐ Gonorrhea | ☐ Mumps | ☐ Bleeding tendency |
| ☐ Syphilis | ☐ Measles | ☐ Chicken pox | ☐ Nervous disorder |
| ☐ Meningitis | ☐ HIV | ☐ Polio | ☐ Mononucleosis |
| ☐ Epilepsy | ☐ High fever | ☐ Hepatitis | ☐ Multiple Sclerosis |
| ☐ Paralysis | ☐ Cancer | ☐ Migraines | ☐ High blood pressure |

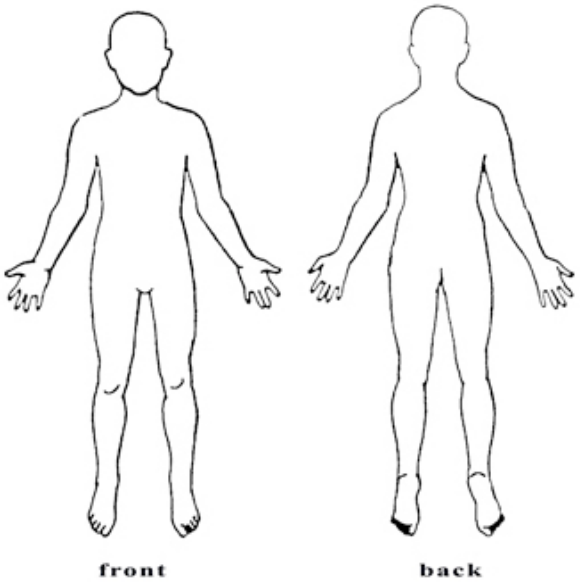
Other:_____

Immunizations:_____

Surgeries:_____

III. **Patient Profile**

Please clearly mark any areas of pain and any scars (please indicate which of the areas are scars):




**Is the pain:**

| | | |
|---|---|---|
| ☐ Sharp | ☐ Burning | ☐ Aching |
| ☐ Cramping | ☐ Dull | ☐ Moving |
| ☐ Fixed | ☐ Other:_____ | |

**Do the following lessen the pain?**

| | | |
|---|---|---|
| ☐ Pressure | ☐ Cold | ☐ Heat |
| ☐ Exercise | ☐ Other:_____ | |

**Do the following worsen the pain?**

| | | |
|---|---|---|
| ☐ Pressure | ☐ Cold | ☐ Heat |
| ☐ Other:_____ | | |

Please check the following that currently pertain to you (if you have symptoms in the following categories, it indicates that you have a problem with that organ's function):

Overall Temperature (Kidney function):

☐ Cold hands
☐ Cold fingers
☐ Cold feet
☐ Cold toes
☐ Sweaty hands
☐ Sweaty feet
☐ Hot body temperature (sensation)
☐ Cold body temperature (sensation)
☐ Afternoon flushes
☐ Night sweats
☐ Heat in the hands, feet, and chest
☐

Hot flashes any time of the day
☐ Thirsty
☐ Perspire easily
☐ Lack of perspiration
☐ Take water to bed

Overall energy (Lung, Kidney function):
☐ Shortness of breath
☐ Difficulty keeping eyes open in the daytime
☐ General weakness
☐ Easily catch colds
☐ Low energy
☐ Feel worse after exercise

Overall blood (Liver, Spleen, Heart function):
☐ Dizziness
☐ See floating black spots

Heart function:
☐ Palpitations
☐ Anxiety
☐ Sores on the tip of the tongue
☐ Restlessness
☐ Mental confusion
☐ Chest pain traveling to shoulder
☐ Frequent dreams
☐ Wake unrefreshed
☐ Drink coffee (# of cups per week: _____)

Lung function:
☐ Nasal Discharge (Color: _____)
☐ Cough
☐ Nose Bleeds
☐ Sinus Congestion
☐ Dry mouth
☐ Dry throat
☐ Dry Nose
☐ Dry Skin
☐ Allergies (To what? _____)
☐ Alternating fever and chills
☐ Sneezing
☐ Headache (Location: _____)
☐ Overall achy feeling in the body
☐ Stiff neck
☐ Stiff shoulders
☐ Sore throat
☐ Difficulty breathing
☐ Smoke cigarettes (# of cigarettes per day: _____)
☐ Sadness
☐ Melancholy

Spleen function:
☐ Low appetite
☐ Abrupt weight gain
☐ Abrupt weight loss
☐ Abdominal bloating
☐ Abdominal gas
☐

Gurgling noise in the stomach
☐ Fatigue after eating
☐ Prolapsed organs (previously diagnosed, which organ? _____)
☐ Easily bruised
☐ Hemorrhoids
☐ Pensive
☐ Over-thinking
☐ Worry

Spleen, Stomach, Large Intestine, Small Intestine function:
☐ Loose
☐ Constipated
☐ Incomplete
☐ Diarrhea
☐ Blood in stools
☐ Mucous in stools
☐ Undigested food in stools

Dampness trapped in the body:
☐ General sensation of heaviness in the body
☐ Mental heaviness
☐ Mental sluggishness
☐ Mental fogginess
☐ Swollen hands
☐ Swollen feet
☐ Swollen joints
☐ Chest congestion
☐ Nausea
☐ Snoring

Stomach function:
☐ Burning sensation after eating
☐ Large appetite
☐ Bad breath
☐ Mouth (canker) sores
☐ Bleeding, swollen or painful gums
☐ Heartburn
☐ Acid regurgitation
☐ Ulcer (diagnosed)
☐ Belching
☐ Hiccoughs
☐ Stomach pain
☐ Vomiting

Liver, Gall Bladder function:
☐ Alternating diarrhea and constipation
☐ Chest pain
☐ Tight sensation in the chest
☐ Bitter taste in the mouth
☐ Anger easily
☐ Frustration
☐ Depression
☐ Irritability
☐ Frequently unable to adapt to stress (What causes the stress? _____)
☐ Skin rashes
☐ Headache at the top of the head
☐ Tingling sensation
☐

Numbness
☐ Muscle spasms
☐ Muscle twitching
☐ Muscle cramping
☐ Seizures
☐ Convulsions
☐ Lump in the throat
☐ Neck tension
☐ Limited Range-of-Motion, Neck
☐ Shoulder tension
☐ Limited Range-of-Motion, Shoulder
☐ Drink alcohol
☐ Recreational drugs (Which? _____, How much per week? _____)
☐ High-pitched ringing in the ears
☐ Gall stones (history or current)
☐ Sexually transmitted disease (Which? _____)

Eyes (Liver function):
☐ Itchy
☐ Bloodshot
☐ Hot
☐ Dry
☐ Watery
☐ Gritty
☐ Blurry vision
☐ Decreased night vision
☐ Near-sighted
☐ Far-sighted

Kidney, Urinary Bladder function:
☐ Frequent cavities
☐ Easily broken bones
☐ Sore knees
☐ Weak knees
☐ Cold sensation in the knees
☐ Low back pain
☐ Memory problems
☐ Excessive hair loss
☐ Low-pitched ringing in the ears
☐ Kidney stones
☐ Bladder infections
☐ Wake during the night twice or more to urinate
☐ Lack of bladder control
☐ Fear
☐ Easily startled

Urination:
☐ Normal color
☐ Dark yellow
☐ Clear
☐ Reddish
☐ Cloudy
☐ Scanty
☐ Profuse
☐ Strong odor
☐ Burning
☐ Painful
☐

Discharge
☐ Difficult
☐ Painful
☐ Urgent
☐ Frequent

Libido:
☐ Normal
☐ High
☐ Low

Do you have an aversion to wind?_____

Do you have an aversion to cold? _____

***Women only*:**

Regular menstrual cycle? Yes No
Number of children:_____
Age of first menstruation:_____
Average number of days of flow:_____
Vaginal discharge? Y N

Pregnant? Yes No
Number of pregnancies:_____
Age of menopause (if applicable):_____
Average number of days of entire cycle:_____
Bleeding between periods? Y N

Do you experience any of the following pre-menstrual syndromes?

☐ nausea ☐ vomiting ☐ water retention ☐ breast swelling
☐ food cravings ☐ headaches ☐ migraines ☐ breast tenderness
☐ depression ☐ irritability ☐ anxiety ☐ other emotions:_____
☐ dull pain, where?_____ ☐ sharp pain, where?_____

Please fill in the following menstrual chart:

| | Day 1 | Day 2 | Day 3 | Day 4 | Day 5 | Day 6 | Day 7 |
|---|---|---|---|---|---|---|---|
| Color (normal, bright red, pale, brown, rust, dark, purple, other) | | | | | | | |
| Amount of flow (normal, heavy, light) | | | | | | | |
| Pain/cramps (location, dull, sharp, other) | | | | | | | |
| Clots (large, small, black, purple, red, other) | | | | | | | |
| Vomiting (check if yes) | | | | | | | |
| Nausea (check if yes) | | | | | | | |
| Other | | | | | | | |

*Men only:*

☐ Swollen testes ☐ Testicular pain Impotence ☐ Premature ejaculation
☐ Feeling of coldness or numbness in external genitalia ☐ Other_____

Are you currently using any medications? Yes No If you answered yes, please tell us:

Name of medication(s): _____

_____

Dosage (mg/timers per day): _____

_____

Prescribed for the following conditions: _____

_____

**Please tell us about your diet. List the food you eat most often for:**

Breakfast: _____

_____

Lunch: _____

_____

Dinner: _____

_____

Snacks: _____

_____

**Do you crave any particular flavors? Check all that apply**:

Sweet_____ Bitter _____

Salty _____

Sour _____

*Please tell us:*

Other Comments:_____

_____

_____

**Patient Signature:** _____

**Acupuncturist Signature:** _____