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Health History Questionnaire **Date**_____

Name:_____

Preferred to be called:_____

Date of Birth:_____

Address:_____ Zip_____

Phone:_____(H) _____(M)

Email:_____

May we contact you via mail or email with newsletters/special offers? __Yes __No

Whom may we thank for referring you to our office? _____

Sex:_____

Gender:_____

Relationship status:_____

Occupation:_____ Employer:_____

Spouse/Partners Name_____

Emergency Contact:_____ Phone: _____

Please describe condition(s) for which treatment is sought:

1._____
Date of onset of symptom(s)_____ Severity of symptoms 1-10 (1 mild/10severe)____
Have you seen your physician about this condition? Yes__ No__

2. _____
Date of onset of symptom(s)_____ Severity of symptoms 1-10 (1 mild/10 severe)____
Have you seen your physician about this condition? Yes__ No__

3._____
Date of onset of symptom(s)_____ Severity of symptoms 1-10 (1 mild/10 severe)____
Have you seen your physician about this condition? Yes__ No__

Have you had acupuncture before? Yes __ No__

Please indicate if any of the following apply to you:

Hemophiliac: Yes __ No__
Pace Maker: Yes __ No__
Heart condition: Yes__ No__
Anticoagulant use: Yes__ No__
Stroke/CVA: Yes__ No__
HIV/AIDS: Yes__ No__
Epilepsy: Yes__ No__
Vegetarian/Vegan: Yes__ No__
Lung Conditions: Yes__ No__
Diabetes: Yes __ Type1__ Type2__ No__
Hepatitis: Yes__ No__
Cancer: Yes__ Where_____ No__

Are you pregnant/is there a chance that you are pregnant? Yes__ No__

Lifestyle/Habits:
Please indicate as appropriate:

Exercise:
__ Mostly sedentary (little to no activity in career/home)
__ Mild exercise (housework, climb stairs, gardening, etc)
__ Occasional vigorous exercise (moderate manual labor, exercise <4x/week for 30min)
__ Regular vigorous exercise (hard manual labor, exercise >4x/week for 30 min)
__ Extreme exercise (professional athlete, serious amateur athlete, exercise 6-7x/week fr >45 min)
What activities do you enjoy to get in your physical activity?

Diet:
Are you on a restrictive diet? Yes__ No__
Is your diet physician prescribed? Yes__ No__
Condition diet is meant to treat?_____
Style/Type of diet:_____
meals eaten in an average day:_____
Estimated oz of water/day:_____
Do you consider your diet “Healthy”? Very__ Somewhat__ No__

Caffeine Intake:
None__ Coffee__ Tea__ Cola/Performance Drink__
cups/cans per day:_____

Alcohol Consumption:
Do you consume alcohol?Yes__ No__
Type of alcohol consumed:_____
# of drinks per week:_____

Tobacco Use:
Do you use tobacco? Yes__ No__
Cigarettes: Packs/day __ Chew: #/day__ Pipe/Cigar#/day__
# of years used:__

Recreational Drug Use:
Do you use recreational drugs? Yes__ No__
Type of drug:_____ Frequency:_____

Family/Community
How often do you see family/friends? 1x/week or less__ 2-4x/week__ >4x/week__
Does your spouse/partner discourage you from attending social events? Yes__ No__
Do you feel safe in your home? Yes__ No__

Other Symptoms/Systems:
Please indicate if you regularly experience any of the following.

Neurological
Concussion___ Stroke____ Brain Surgery___ Multiple Sclerosis___ Parkinson's___
TIA (stroke that went away)___ Brain Tumor____ Meningitis____ Head Injury___
Falls___ Tremors____ Neuropathy____ Problems with walking/Balance___
Spells of loss of consciousness____

Other/Date of occurrence of any of the above if relevant:

_____

_____

Head & Neck
Dizziness__ Fainting__ Stiff Neck__ Enlarged lymph glands__ Headache__ Location_____

Other:_____

Eyes & Ears:
Blurred vision__ Visual changes__ Spots/Floaters__ Eye pain__ Dry Eyes__ Poor night vision__ red/burning/itchy eyes__ Earache__ Vertigo__ Ringing in ears__ Chronic ear infection__ Decreased hearing__

Other:_____

Respiratory/Nose:
Chronic cough__ Coughing up blood__ Cough with Phlegm__ Difficulty breathing__ Shortness of breath__ Wheezing/asthma__ Frequent colds__ Chronic sinus infections__ Nasal congestion __ Bronchitis__ Hay fever/allergies__ Nosebleeds__

Other:_____

Cardiovascular:
Heart palpitations__ Chest pain/tightness__ Poor circulation__ Varicose veins__
Irregular heart beat __ Swelling in feet/ankles__

Other:_____

Mouth & Throat:
Bleeding gums__ Recurrent sore throat__ Bitter taste in mouth__ Dry mouth__ Tongue/mouth__ Sores/Ulcers__ Difficulty swallowing__ Lump in throat

Other:_____

Skin:
Hives/rashes__ Acne__ Dry skin__ Eczema/psoriasis__ Bruise easily__ Itchy skin__ Spontaneous sweat__ Brittle/weak nails__ Night sweats__ Change in moles/lumps__

Other:_____

Gastrointestinal:
Nausea__ Vomiting__ Gas__ Rectal pain/itchiness__ Hiccups__ Bloating__ Bad breath__ Acid reflux/heartburn__ Loose/soft stool__ Constipation__ Anal fissure__ Hemorrhoids__
Mucus in stool__ Blood in stool__ Black stool__ Laxative use__ Intestinal pain/cramping__
Alternating diarrhea/Constipation__

Other:_____

Sleep:
Sound/restful__ Trouble falling asleep__ Trouble staying asleep__ Wake easily/early__
Dream disturbed__ Vivid dreaming/nightmare__ Difficulty waking up__ # of hours sleep/night__

Other:_____

Emotions:
Relaxed/calm__ Sad/Grief/Depressed__ Fearful__ Impatient__ Angry/Frustrated__
Forgetful/Poor memory__ Anxious__ Stressed__ Manic__

Other:_____

General:
Cold hands/feet__ Always feels hot__ Always feels cold__ Fever & chills__

Recent unexplained weight changes__ Fatigue__

Tests
What diagnostic have you done so far? (complete blood count, metabolic panal, food sensitivity, EEG, MRI, CT, X-ray, etc.)

_____

Hospitalizations:
Please list any hospitalizations:

_____

_____

Musculoskeletal:
Pain or numbness in any of the following areas - for pain, please rate levels using a scale from 0-10, 0 is no pain and 10 is the worst.

___neck	___shoulders	___arms/elbows	___wrist/hands
___knees	___feet	___spinal stenosis	___scoliosis
___leg or calf cramping		___muscle weakness	___muscle spasms
___rheumatoid arthritis		___bursitis	___thighs
___calves	___legs	___poor posture	___sciatica
___low back pain	___swollen joints	___numbness in toes	___numbness in fingers
___degenerative joint disorder		___degenerative disc	

What relieves your pain/condition?_____
Heat__ Cold__ Damp__ Weather__ Wind__ Medications__ Pressure__

What aggravates your pain/condition?_____
Heat__ Cold__ Damp__ Weather__ Wind__ Medications__ Pressure__

List any medications, vitamins, herbs, homeopathics and supplements you are currently taking:(continue on back if needed) Medicine Dosage Reason How Long

_____

_____

For Women:
Date of last period_____ Age of 1st period (menarche)_____ Age of last period (menopause)_____
Number of days between periods_____ Number of days of flow_____ Color of flow_____
Clots?_____Color_____ Do you use pads or tampons? (circle one or

both) Avg # per day Day 1_____Day 2_____Day 3_____ Day 4_____Day 5_____Day 6_____+Days_____ Cramps Nature of your cramps and at what time of the cycle?

Cramping__ Dull__
Stabbing__ Bloating__
Burning__ Aching__

What relieves your cramping?_____
Are you pregnant?_____Trying?_____
# of pregnancies__ # of miscarriages__ # of live births__ # of abortions__
Date of last ob/gyn exam + results_____
Pap Smear__ Mammogram__ Bone Density Scan__

Other symptoms related to menses:

discharge__ vaginal dryness__ Headache__
Insomnia__ flashes__ Night sweats__ Ravenous Appetite__
poor appetite__ libido__ Swollen breasts__
mood swings__ Nausea__ Constipation__

Have you been diagnosed with (include year): fibroids_____ endometriosis_____
PI _____ Ovarian cysts_____ fibrocystic breasts_____

For Men:

Date of last prostate exam_____PSA results_____Manual prostate exam results_____
Frequency of urination: daytime_____nighttime_____
color of urine_____odor_____
Symptoms related to prostate:

prostate problems__ delayed stream__ dribbling__ incontinence__
retention of urine__ impotence__ groin pain__ testicular pain__
premature ejaculation__ back pain__ dec. libido__
Inc. libido__ Rectal dysfunction__
Other_____
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