

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: ___/___/___

Name: _____

Address: _____

City, State, Postal Code: _____

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

Email: _____

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

Guardian (if under 18): _____

Gender: M F Height: ___'___" Weight: _____lbs.

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: _____

Surgeries: _____

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

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

Test Results and Date: _____

Circle any you have had in the past

<input type="checkbox"/> Diabetes	<input type="checkbox"/> Allergies	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Rheumatic Fever
<input type="checkbox"/> Heart Disease	<input type="checkbox"/> CVA (stroke)	<input type="checkbox"/> Vein condition	<input type="checkbox"/> Thyroid disorder
<input type="checkbox"/> Asthma	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Emphysema
<input type="checkbox"/> Jaundice	<input type="checkbox"/> Gonorrhea	<input type="checkbox"/> Mumps	<input type="checkbox"/> Bleeding tendency
<input type="checkbox"/> Syphilis	<input type="checkbox"/> Measles	<input type="checkbox"/> Chicken pox	<input type="checkbox"/> Nervous disorder
<input type="checkbox"/> Meningitis	<input type="checkbox"/> HIV	<input type="checkbox"/> Polio	<input type="checkbox"/> Mononucleosis
<input type="checkbox"/> Epilepsy	<input type="checkbox"/> High fever	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Multiple Sclerosis
<input type="checkbox"/> Paralysis	<input type="checkbox"/> Cancer	<input type="checkbox"/> Migraines	<input type="checkbox"/> High blood pressure
<input type="checkbox"/> other lung illnesses	<input type="checkbox"/> other liver illnesses	<input type="checkbox"/> other heart illnesses	<input type="checkbox"/> other kidney illnesses
<input type="checkbox"/> other: _____			

III. Patient Profile

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

Is the pain:

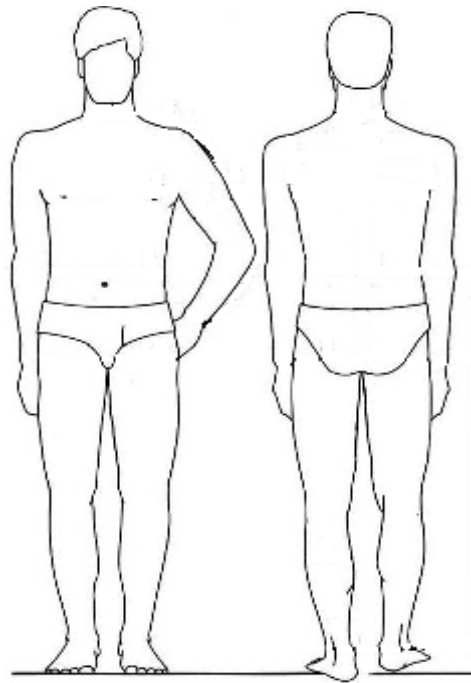
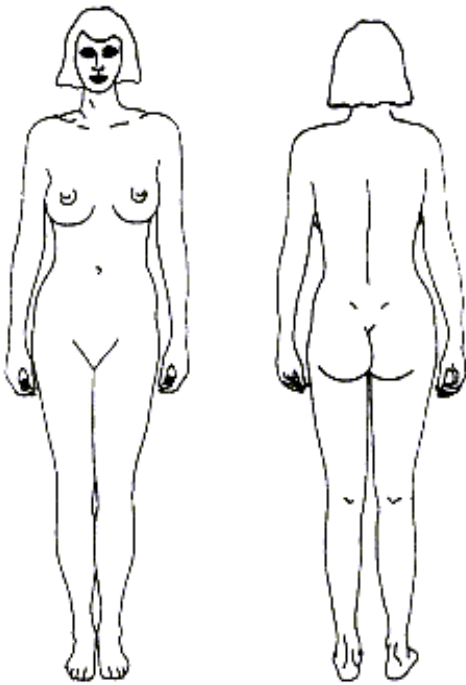
<input type="checkbox"/> Sharp	<input type="checkbox"/> Burning	<input type="checkbox"/> Aching
<input type="checkbox"/> Cramping	<input type="checkbox"/> Dull	<input type="checkbox"/> Moving
<input type="checkbox"/> Fixed	Other: _____	

Do the following lessen the pain?

<input type="checkbox"/> Pressure	<input type="checkbox"/> Cold	<input type="checkbox"/> Heat
<input type="checkbox"/> Exercise	Other: _____	

Do the following worsen the pain?

<input type="checkbox"/> Pressure	<input type="checkbox"/> Cold	<input type="checkbox"/> 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:

- 0Palpitations
- 0Anxiety
- 0Sores on the tip of the tongue
- 0Restlessness
- 0Mental confusion
- 0Chest pain traveling to shoulder
- 0Frequent dreams
- 0Wake unrefreshed
- 0Drink coffee (# of cups per week: _____)

Lung function:

- 0Nasal Discharge (Color: _____)
- 0Cough
- 0Nose Bleeds
- 0Sinus Congestion
- 0Dry mouth
- 0Dry throat
- 0Dry Nose
- 0Dry Skin
- 0Allergies (To what? _____)
- 0Alternating fever and chills
- 0Sneezing
- 0Headache (Location: _____)
- 0Overall achy feeling in the body
- 0Stiff neck
- 0Stiff shoulders
- 0Sore throat
- 0Difficulty breathing
- 0Smoke cigarettes (# of cigarettes per day: _____)
- 0Sadness
- 0Melancholy

Spleen function:

- 0Low appetite
- 0Abrupt weight gain
- 0Abrupt weight loss
- 0Abdominal bloating
- 0Abdominal gas
- 0Gurgling noise in the stomach
- 0Fatigue after eating
- 0Prolapsed organs (previously diagnosed, which organ? _____)
- 0Easily bruised
- 0Hemorrhoids
- 0Pensive
- 0Over-thinking
- 0Worry

Spleen, Stomach, Large Intestine, Small Intestine function:

- 0Loose
 - 0Constipated
 - 0Incomplete
 - 0Diarrhea
 - 0Blood in stools
 - 0Mucous in stools
 - 0Undigested food in stools
-

Dampness trapped in the body:

- θGeneral sensation of heaviness in the body
- θMental heaviness
- θMental sluggishness
- θMental fogginess
- θSwollen hands
- θSwollen feet
- θSwollen joints
- θChest congestion
- θNausea
- θSnoring

Stomach function:

- θBurning sensation after eating
- θLarge appetite
- θBad breath
- θMouth (canker) sores
- θBleeding, swollen or painful gums
- θHeartburn
- θAcid regurgitation
- θUlcer (diagnosed)
- θBelching
- θHiccoughs
- θStomach pain
- θVomiting

Liver, Gall Bladder function:

- θAlternating diarrhea and constipation
 - θChest pain
 - θTight sensation in the chest
 - θBitter taste in the mouth
 - θAnger easily
 - θFrustration
 - θDepression
 - θIrritability
 - θFrequently unable to adapt to stress (What causes the stress? _____)
 - θSkin rashes
 - θHeadache at the top of the head
 - θTingling sensation
 - θNumbness
 - θMuscle spasms
 - θMuscle twitching
 - θMuscle cramping
 - θSeizures
 - θConvulsions
 - θLump in the throat
 - θNeck tension
 - θLimited Range-of-Motion, Neck
 - θShoulder tension
 - θLimited Range-of-Motion, Shoulder
 - θDrink alcohol
 - θRecreational drugs (Which? _____, How much per week? _____)
 - θHigh-pitched ringing in the ears
 - θGall stones (history or current)
 - θSexually transmitted disease (Which? _____)
-

Eyes (Liver function):

- θItchy
- θBloodshot
- θHot
- θDry
- θWatery
- θGritty
- θBlurry vision
- θDecreased night vision
- θNear-sighted
- θFar-sighted

Kidney, Urinary Bladder function:

- θFrequent cavities
- θEasily broken bones
- θSore knees
- θWeak knees
- θCold sensation in the knees
- θLow back pain
- θMemory problems

- θExcessive hair loss
- θLow-pitched ringing in the ears
- θKidney stones
- θBladder infections
- θWake during the night twice or more to urinate
- θLack of bladder control
- θFear
- θEasily startled

Urination:

- θNormal color
- θDark yellow
- θClear
- θReddish
- θCloudy
- θScanty
- θProfuse
- θStrong odor
- θBurning
- θPainful
- θDischarge
- θDifficult
- θPainful
- θUrgent
- θFrequent

Libido:

- θNormal
- θHigh
- θLow

IV. List ALL the medications you are currently taking. Please include vitamins and other supplements.

Men only:

θSwollen testes θTesticular pain θImpotence θPremature ejaculation
θFeeling of coldness or numbness in external genitalia θOther_____

All please fill out:

Other Comments:_____

Patient Signature:_____

Acupuncturist Signature:_____