

**Acupuncture Therapy
HEALTH HISTORY QUESTIONNAIRE**

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

Name _____ **Date** _____

Street _____ **City** _____

State _____ **Zip** _____

Home Phone _____ **Work Phone** _____

Cell Phone _____ **E-Mail** _____

Date of Birth _____ **Age** _____ **Male** _____ **Female** _____

Height _____ **Weight** _____

Marital Status: Married Never Married Widowed Divorced or Separated

Education: Grammar School High School College Masters Doctorate

Occupation:

Family Physician :

Referred by:

Emergency Contact:

Relation to you:

Emergency Contact telephone:

Main Condition (s) you would like us to help you with:

How long ago did this problem begin? Please be specific:

Have you been given a diagnosis for this problem? If so, what diagnosis and by whom?

What other kinds of treatment have you tried? Western Medicine Acupuncture
 Herbs Massage Physical Therapy Chiropractor Reiki Homeopathy
 Other:

Past Personal Medical History of Significant Illnesses:

Asthma Allergies Diabetes Cancer Stroke Heart disease
 High Blood Pressure Seizures Hepatitis Rheumatic Fever
 Thyroid disease Venereal disease

Other:

Hospitalizations/Surgeries (including dates): _____

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

Allergies (drugs, chemicals, foods, metals):

Family Medical History: (check all that are applicable)

- Asthma Allergies Diabetes Cancer Stroke Heart disease
 High Blood Pressure Seizures Thyroid Hepatitis Rheumatic Fever
 Thyroid disease Venereal disease Other:

Medicines taken within the last two months :

Vitamins, herbs, etc:

Are there any areas of your life that you find stressful? Please describe

Do you have a regular exercise program? No Yes Describe

Do you follow any type of special diet (e.g. vegetarian, vegan, medical related, or other)?

No Yes If yes, what type of diet?

Describe your average daily diet:

Morning:

Afternoon:

Evening:

Do you smoke? No Yes **If Yes, how many cigarettes or cigars per day?**

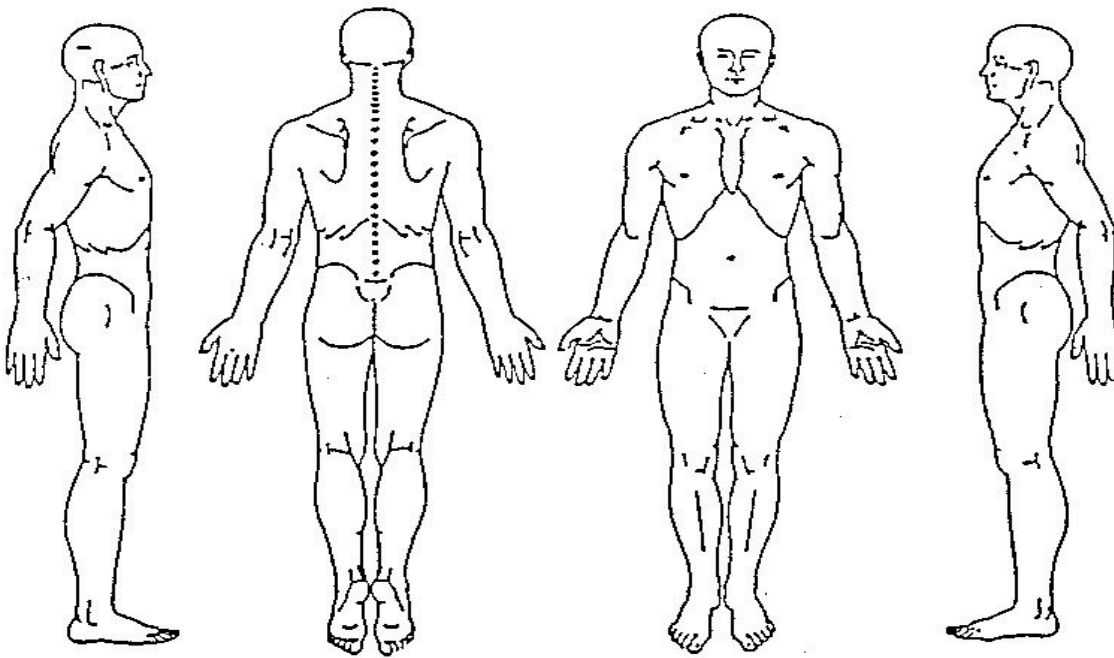
How many cups of caffeinated coffee, tea, or cola do you drink per day?

How many 8 oz. glasses of water do you drink per day?

How many alcoholic beverages do you drink per week?

Please describe any use of drugs for non-medical purposes

Please indicate any painful or distressed body areas by circling the particular area:



Pain scale for areas marked: 0-10 (10 being most painful) Please list below:

Please check if you have had any of the following, particularly in the last three months:

MUSCULOSKELETAL:

- Neck pain
 - Rotator cuff
 - Knee pain
 - Foot/ankle pain
 - Muscle pain
 - Muscle pain
 - Muscle weakness
 - Shoulder pain
 - Hip pain
 - Sciatica
 - Bursitis
 - Hand/wrist pain
 - Carpal tunnel
 - Sprains/strains
 - Tendonitis
 - Back pain: Low Middle Upper_____
 - Soreness/weakness of lower body (back, hip, knee, ankle, foot)
-

GENERAL:

- Fevers
 - Chills
 - Fatigue
 - Sweat easily
 - Poor sleeping
 - Night sweats
 - Weight loss
 - Cravings
 - Weight gain
 - Change in appetite
 - Strong thirst for: Hot drinks Cold drinks
 - Sudden energy drop, if so what time of day?_____
 - Bleed or bruise easily
 - Peculiar tastes or smells
-

SKIN & HAIR:

- Rashes
 - Ulcerations
 - Hives
 - Itching
 - Eczema
 - Pimples
 - Dandruff
 - Loss of hair
 - Recent moles
 - Psoriasis
 - Dermatitis
 - Acne
 - Change in hair or skin texture
 - Any other skin or hair problems?
-

HEAD, EYES, EARS, NOSE & THROAT:

- Dizziness
 - Concussions
 - Migraines
 - Glasses
 - Eye strain
 - Eye pain
 - Poor vision
 - Night blindness
 - Color blindness
 - Cataracts
 - Blurry vision
 - Earaches
 - Ringing in ears
 - Spots in front of eyes
 - Poor hearing
 - Sinus problems
 - Nose bleeds
 - Recurrent sore throats
 - Grinding teeth
 - Clenching jaw
 - Facial pain
 - Sores on lips or tongue
 - Teeth problems
 - Jaw clicks
 - Headaches, where and when?
 - Any other head or neck problems?
-

CARDIOVASCULAR:

- High blood pressure
- Low blood pressure
- Chest pain
- Fainting
- Irregular heart beat
- Difficulty in breathing
- Blood clots
- Phlebitis
- Cold hands or feet
- Swelling of hands
- Swelling of feet
- Varicose or spider veins
- Palpitations
- Palpitations at rest
- Any other heart or blood vessel problems?

RESPIRATORY:

- Cough
 - Pneumonia
 - Difficulty breathing when lying down
 - Coughing blood
 - Pain with deep breath
- Asthma
 - Chest tightness
 - Phlegm production, what color?
 - Bronchitis
-

GASTROINTESTINAL:

- Nausea
 - Gas
 - Indigestion
 - Bleeding gums
 - Hernia
 - Colitis
 - Chronic laxative use
 - Any other problem with Stomach or intestines?
 - Vomiting
 - Belching
 - Bad breath
 - Food stagnation
 - Excessive appetite
 - Slow digestion
- Diarrhea
 - Black stools
 - Rectal pain
 - Bloating/edema
 - Poor appetite
 - Abdominal pain/cramps
 - Loose stools, more than 2 per day
- Constipation
 - Blood in stools
 - Hemorrhoids
 - Acid reflux/GERD
 - IBS/Crohn's disease
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GENITO-URINARY:

- Frequent urination
 - Urgency to urinate
 - Decrease in flow
 - Any particular color to your urine?
 - Do you wake up at night to urinate? If yes, how many times a night?
 - Any other problems with your genital or urinary systems?
 - Blood in urine
 - Unable to hold urine
 - Impotency
- Pain upon urination
 - Kidney stones
 - Sores on genitals
-

OB & GYN:

- Are you pregnant? Yes No
- Number of pregnancies: _____
- Abortions: _____
- Age at first menses: _____
- Duration of menses: _____
- Irregular periods Painful periods Clots Breast lumps
- Vaginal sores Vaginal discharge Vaginal dryness Endometriosis
- Uterine fibroids Polycystic Ovarian disease Fibrocystic breast tissue
- Unusual character of blood (heavy, scanty)
- Do you practice birth control? Yes No If yes, what type? _____ How long? _____
- Is it possible that you are pregnant? Yes No
- Live Births: _____ Miscarriages: _____
- Premature births: _____
- Time period between menses: _____
- Last PAP: _____
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NEUROLOGICAL & PSYCHOLOGICAL:

- Seizures
 - Poor memory
 - Bad temper
 - ADD/ADHD
 - Dizziness
 - Concussion
 - Anxiety
 - Manic depression
 - Loss of balance
 - Poor coordination
 - Depression
 - Areas of numbness
 - Easily susceptible to stress
 - Nervousness
- Have you ever been treated for emotional problems? Yes No
- Have you ever considered or attempted suicide? Yes No
- Any other neurological or psychological problems? _____

COMMENTS: *Please tell us briefly of any other problems you would like to discuss.*