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?

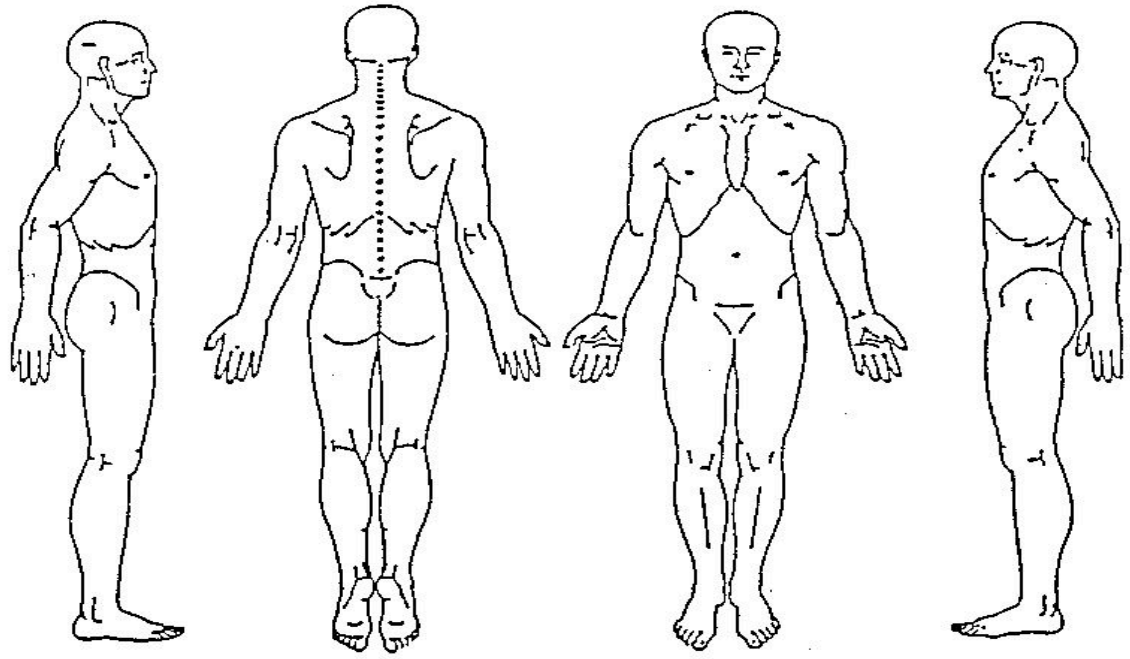
How many cups of caffeinated coffee, tea, or cola do you drink per day?

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 of blood vessel problems?

RESPIRATORY:

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

GASTROINTESTINAL:

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

GENITO-URINARY:

□ Frequent urination □ Blood in urine □ Pain upon urination
□ Urgency to urinate □ Unable to hold urine □ Kidney stones
□ Decrease in flow □ Impotency □ Sores on genitals
□ 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?

OB & GYN:

Are you pregnant? □ Yes □ No Is it possible that you are pregnant? □ Yes □ No
Number of pregnancies: Live Births: Miscarriages:
Abortions: Premature births:
Age at first menses: Time period between menses:
Duration of menses: Last PAP:
□ 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?

NEUROLOGICAL & PSYCHOLOGICAL:

□ Seizures □ Dizziness □ Loss of balance □ Areas of numbness
□ Poor memory □ Concussion □ Poor coordination □ Easily susceptible to stress
□ Bad temper □ Anxiety □ Depression □ Nervousness
□ ADD/ADHD □ Manic depression
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.*