



Health History Questionnaire

Please help me 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. Some questions may seem unrelated to your main complaint—this is because acupuncture looks at the whole person. How your different systems are working and interacting may help in the diagnosis and aid in treatment of the main problem.

Name: _____ Age _____ Birth Date _____ Sex: M / F

Address _____ City _____ Zip Code _____

Evening Phone _____ Day Phone _____ Social Security # _____

In Emergency, Notify _____ Phone _____

Referred by _____ Family Physician _____

Current Health Concerns

Please list your health concerns. Begin with the most important to address today.

Classify your health concern as 1= Minor; 2 = Moderate; 3 = Fairly severe and getting worse; 4 = Serious
Classified As Date of Onset

- | | | | |
|----|-------|-------|-------|
| 1. | _____ | _____ | _____ |
| 2. | _____ | _____ | _____ |
| 3. | _____ | _____ | _____ |

To what extent do these problems interfere with or impact your daily activities (work, sleep, play)?

What type of service(s) do you desire?

- _____ 1. Relief of symptoms/ pain control
- _____ 2. Eradication of tendencies causing your condition
- _____ 3. Holistically and balanced health, including emotions – elimination of root/cause of problem
- _____ 4. Maintenance-care – regular balancing and "tune-ups" to keep in optimum health; proactive

Please list some of the most significant events in your life, beginning with the most recent, (such as marriage/divorce, birth of child, career changes, personal or professional recognition, periods of grief, accidents)

- 1. _____
- 2. _____
- 3. _____

Please list any hospitalizations, surgery, serious injuries, and recent dental work with a short description and date.

Current & Former Conditions

Do You Have Any Of The Following?

√ Check Mark any of the following that you are experiencing now or have experienced in the past 3 months.

General Symptoms	Ears, Eyes, Nose & Throat	Cardiovascular
<input type="checkbox"/> Headache or Migraines	<input type="checkbox"/> Facial or Eye pain	<input type="checkbox"/> High blood pressure
<input type="checkbox"/> Feels warm most of the time	<input type="checkbox"/> Failing vision/ eye strain	<input type="checkbox"/> Low blood pressure
<input type="checkbox"/> Abnormal sweating	<input type="checkbox"/> Eye inflammation	<input type="checkbox"/> Irregular heartbeat
<input type="checkbox"/> Night sweats or wake from warmth	<input type="checkbox"/> Poor vision/ blurred vision	<input type="checkbox"/> Palpitations
<input type="checkbox"/> Feels cold most of the time	<input type="checkbox"/> Spots floating in eyes	<input type="checkbox"/> Chest pain/ pressure
<input type="checkbox"/> Fatigue	<input type="checkbox"/> Dry eyes	<input type="checkbox"/> Varicose veins
<input type="checkbox"/> Fainting	<input type="checkbox"/> Ear discharges	<input type="checkbox"/> Swelling in hands/ feet
<input type="checkbox"/> Dizziness/ tremors	<input type="checkbox"/> Earaches	Neurological
<input type="checkbox"/> Convulsions	<input type="checkbox"/> Poor hearing	<input type="checkbox"/> Spasms
<input type="checkbox"/> Decreased motivation	<input type="checkbox"/> Ringing in the ears	<input type="checkbox"/> Numbness/ tingling
<input type="checkbox"/> Difficulty focusing	<input type="checkbox"/> TMJ	<input type="checkbox"/> Paralysis
<input type="checkbox"/> Poor memory	<input type="checkbox"/> Tooth or gum problems	Female
<input type="checkbox"/> Decreased libido	<input type="checkbox"/> Frequent cold sores	<input type="checkbox"/> Pregnancies _____
Respiratory	<input type="checkbox"/> Teeth grinding	<input type="checkbox"/> Births _____
<input type="checkbox"/> Chronic Cough	<input type="checkbox"/> Nose bleeds	<input type="checkbox"/> Premature/ Miscarriages _____
<input type="checkbox"/> Coughing with blood	<input type="checkbox"/> Nasal congestion	<input type="checkbox"/> Stillborn/ Abortions _____
<input type="checkbox"/> Difficulty breathing	<input type="checkbox"/> Hay fever/ allergies	<input type="checkbox"/> First menses _____
<input type="checkbox"/> Shortness of breath	<input type="checkbox"/> Asthma	<input type="checkbox"/> Last pap _____
<input type="checkbox"/> Spitting up phlegm	<input type="checkbox"/> Loss of taste	<input type="checkbox"/> Date of last menses _____
<input type="checkbox"/> Frequent colds/ flu	<input type="checkbox"/> Recurrent sore throat	<input type="checkbox"/> Duration of menses _____
Gastrointestinal	Dermatology	<input type="checkbox"/> Days between menses _____
<input type="checkbox"/> Nausea/ Vomiting	<input type="checkbox"/> Acne	<input type="checkbox"/> Painful menstrual periods
<input type="checkbox"/> Poor appetite	<input type="checkbox"/> Rashes/ Hives	<input type="checkbox"/> Pre-menstrual emotions
<input type="checkbox"/> Food cravings	<input type="checkbox"/> Itchy skin	<input type="checkbox"/> Excessive flow
<input type="checkbox"/> Indigestion	<input type="checkbox"/> Dry skin	<input type="checkbox"/> Hot flashes/ night sweats
<input type="checkbox"/> Abdominal pain	<input type="checkbox"/> Bruise easily	<input type="checkbox"/> Cramps or backache
<input type="checkbox"/> Flatulence	<input type="checkbox"/> Clammy skin	<input type="checkbox"/> Breast soreness/ lumps
<input type="checkbox"/> Bloating	Genitourinary	<input type="checkbox"/> Vaginal discharge
<input type="checkbox"/> Loose stools/ diarrhea	<input type="checkbox"/> Bladder problems/ UTIs	<input type="checkbox"/> Vaginal sores/ History of STD's

Male Issues	<input type="checkbox"/> Pain/Burning with urination	Emotions
<input type="checkbox"/> Last prostate exam _____	<input type="checkbox"/> Blood in urine	<input type="checkbox"/> Irritability/ anger issues
<input type="checkbox"/> Impotence/ Fertility issues	<input type="checkbox"/> Urgency to urinate	<input type="checkbox"/> Depression
<input type="checkbox"/> Penile Sores/ discharge	<input type="checkbox"/> Frequent urination	<input type="checkbox"/> Anxiety
Musculoskeletal	<input type="checkbox"/> Difficulty urinating	<input type="checkbox"/> Mood Swings
<input type="checkbox"/> Joint Pain Stiffness	<input type="checkbox"/> Incontinence	<input type="checkbox"/> Recent loss
<input type="checkbox"/> Muscle weakness	<input type="checkbox"/> Scanty dark urine	<input type="checkbox"/> Fear
<input type="checkbox"/> Bone problems/ Arthritis	<input type="checkbox"/> Abundant pale urination	<input type="checkbox"/> Ongoing worry

Medications/ Vitamins

Please list all your medications (including sleeping pills, birth control) and non-prescription drugs (such as Aspirin, antacids, laxatives, antihistamines) that you take on a regular basis.

Please list all vitamin supplements you are taking on a regular basis and their dosage.

Please indicate painful or distressed areas on the diagram

Family History

Place a check \checkmark for those diseases one or both of your parents had; place a plus + for any diseases your siblings have; you may place both a check and plus if necessary.

<input type="checkbox"/> Cancer	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Depression	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> High BP
<input type="checkbox"/> Stroke	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Mental illness	<input type="checkbox"/> Asthma	<input type="checkbox"/> Kidney disease
<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Thyroid disease	<input type="checkbox"/> MS	<input type="checkbox"/> Neurological disease
Other _____		<input type="checkbox"/> Autoimmune disease		

Please note the degree of severity of your problem now:

0	1	2	3	4	5	6	7	8	9	10	
Lowest											Highest

Please note the greatest degree of severity of your problem within this past week:

0	1	2	3	4	5	6	7	8	9	10	
Lowest											Highest

Thank you for your time spent with this form. I appreciate your time spent, but also your willingness to share things that maybe are not normally asked.
