

# Health History Questionnaire

## Information for your Acupuncturist.

Please complete this document as thoroughly as possible. Some of the questions that follow may seem unrelated to your condition, however, they may play a major role in diagnosis and treatment.

### General Patient Information

Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Email: \_\_\_\_\_ Would you like to receive our e-mail newsletter?  YES  NO

Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Place of Birth: \_\_\_\_\_

Marital Status:  Married  Single  Divorced  Widowed  Domestic Partnership  Other

Name of Spouse/Partner/Other: \_\_\_\_\_

Guardian (if under 18): \_\_\_\_\_

Gender:  MALE  FEMALE Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Social Security Number: \_\_\_\_\_ Drivers License Number: \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Employer Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Goal from acupuncture or other services we offer: \_\_\_\_\_

Does anything limit you from care?  NO  YES (explain) \_\_\_\_\_

How did you hear about our office? \_\_\_\_\_

Other physicians/therapists seen for this: \_\_\_\_\_

Medications (if any): \_\_\_\_\_

Prescribed by: \_\_\_\_\_

Treatment(s): \_\_\_\_\_

Results: \_\_\_\_\_

Supplements/Vitamins/Herbs: \_\_\_\_\_

**Major complaints, in order of significance to you:**

_____	SEVERE	MODERATE	SLIGHT	NORMAL
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	SEVERE	MODERATE	SLIGHT	NORMAL
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	SEVERE	MODERATE	SLIGHT	NORMAL
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	SEVERE	MODERATE	SLIGHT	NORMAL
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	SEVERE	MODERATE	SLIGHT	NORMAL
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	SEVERE	MODERATE	SLIGHT	NORMAL
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

How do these conditions impair your daily activities? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Patient Medical History**

How was your childhood health? \_\_\_\_\_  
Hospital Visits/Stays: \_\_\_\_\_  
\_\_\_\_\_

Recent tests (*indicate results and date below*)

- Physical       Cholesterol       Prostate       Blood (which?) \_\_\_\_\_
- HIV/STD       Pap smear       Mammography       Hormone (saliva)
- Thermography       Other

Test Results and date: \_\_\_\_\_  
\_\_\_\_\_

**Check 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 Illness   | <input type="checkbox"/> Other Liver Illness   | <input type="checkbox"/> Other Heart Illness | <input type="checkbox"/> Other Kidney Illness |
| <input type="checkbox"/> Other Spleen Illness | <input type="checkbox"/> Other Stomach Illness |  |   |
| <input type="checkbox"/> Other: _____         |  |  |   |

Immunizations: \_\_\_\_\_

Surgeries: \_\_\_\_\_

**Family History:**

Father	Alive	Deceased	Present Health/Cause of Death
_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Mother	Alive	Deceased	Present Health/Cause of Death
_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Spouse	Alive	Deceased	Present Health/Cause of Death
_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Child	Alive	Deceased	Present Health/Cause of Death
_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Child	Alive	Deceased	Present Health/Cause of Death
_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Sibling	Alive	Deceased	Present Health/Cause of Death
_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Sibling	Alive	Deceased	Present Health/Cause of Death
_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Sibling	Alive	Deceased	Present Health/Cause of Death
_____	<input type="checkbox"/>	<input type="checkbox"/>	_____

Where are you in the birth order?  First  Last  Middle  Only  Other: \_\_\_\_\_

**Check the following that have occurred in your blood relatives:**

- |   |                                       |  |  |
|---|---------------------------------------|--|--|
| <input type="checkbox"/> Diabetes       | <input type="checkbox"/> Cancer       | <input type="checkbox"/> Heart Disease   | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Allergies      | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Obesity         | <input type="checkbox"/> Bleeding Tendency   |
| <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Alcoholism   | <input type="checkbox"/> Nervous Illness | <input type="checkbox"/> Mental Illness      |
| <input type="checkbox"/> Stroke         | <input type="checkbox"/> Unsure       | <input type="checkbox"/> Other: _____    |  |

**Patient Profile:**

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

**Is the pain:**

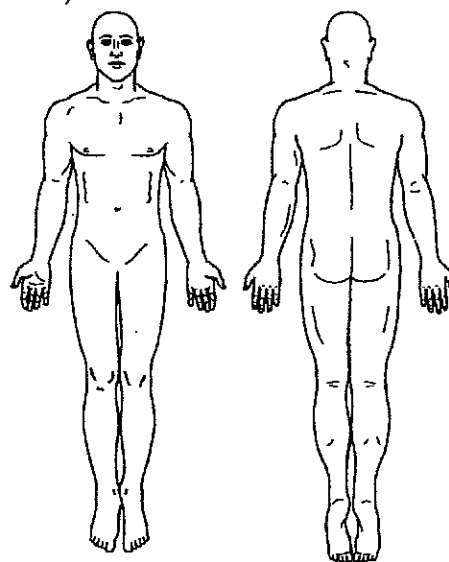
- |                                   |                                       |                                 |
|-----------------------------------|---------------------------------------|---------------------------------|
| <input type="checkbox"/> Sharp    | <input type="checkbox"/> Burning    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

**Do the following lessen the pain:**

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

**Do the following worsen the pain:**

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



**Please check the following that pertain to you:**

**Overall Temperature (Kidney Function):**

- |  |  |
|--|--|
| <input type="checkbox"/> Cold hands                                  | <input type="checkbox"/> Cold feet                         |
| <input type="checkbox"/> Sweaty hands                                | <input type="checkbox"/> Sweaty feet                       |
| <input type="checkbox"/> Hot body temperature (sensation)            | <input type="checkbox"/> Cold body temperature (sensation) |
| <input type="checkbox"/> Afternoon flushes                           | <input type="checkbox"/> Night sweats                      |
| <input type="checkbox"/> Heat in the hands, feet, and chest          | <input type="checkbox"/> Hot flashes any time of the day   |
| <input type="checkbox"/> Thirsty                                     | <input type="checkbox"/> Perspire easily                   |
| <input type="checkbox"/> Lack of perspiration                        | <input type="checkbox"/> Take water to bed                 |
| <input type="checkbox"/> Difficulty keeping eyes open in the daytime |  |

**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

**BLOOD (Liver, Spleen, Heart Function)**

- Dizziness
- See floating black spots

**HEART FUNCTION**

- Palpitations
- Anxiety
- Sores on the tip of the tongue
- Restlessness
- Mental confusion
- Chest pain traveling to shoulder
- Frequent dreams
- Wake unrefreshed
- Drink coffee (#\_\_\_\_\_ cups/week)
- Knee pain

**LUNG FUNCTION**

- Nasal discharge (color: \_\_\_\_\_)
- Cough
- Nose bleeds
- Sinus congestion
- Dry mouth
- Dry throat
- Dry nose
- Dry skin
- Allergies (to what? \_\_\_\_\_)
- Alternating fever/chills
- Sneezing
- Headache (location? \_\_\_\_\_)
- Overall achy feeling in the body
- Stiff neck
- Stiff shoulders

- Sore throat
- Difficulty breathing
- Smoke cigarettes (#\_\_\_\_\_ /day)
- Sadness
- Melancholy

**SPLEEN FUNCTION**

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

**SPLEEN, STOMACH, LARGE AND SMALL INTESTINE FUNCTION**

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

**DAMPNESS TRAPPED IN THE BODY**

- General sensation of heaviness in the body
- Mental heaviness
- Mental sluggishness
- Mental fogginess
- Swollen hands
- Swollen feet
- Swollen joints

**DAMPNESS TRAPPED IN THE BODY (cont.)**

- Chest congestion
- Nausea
- Snoring

**STOMACH FUNCTION**

- Burning sensation after eating
- Large appetite
- Bad breath
- Mouth (canker) sores
- Bleeding, swollen, or painful gums
- Heartburn
- Acid regurgitation
- Ulcer (diagnosed)
- Belching
- Hiccoughs
- Stomach pain
- Vomiting
- Thirst with no desire to drink

**LIVER, GALL BLADDER FUNCTION**

- Alternating diarrhea and constipation
- Chest pain
- Tight sensation in the chest
- Bitter taste in the mouth
- Anger easily
- Frustration
- Depression
- Irritability
- Frequently unable to adapt to stress  
(caused by? \_\_\_\_\_)
- Skin rashes
- Headache at the top of the head
- Tingling sensation
- Numbness
- Muscle spasms
- Muscle twitching
- Muscle cramping
- Seizures

- Convulsions
- Lump in the throat
- Neck tension
- Limited range-of-motion, neck
- Shoulder tension
- Limited range-of-motion, shoulder
- Drink alcohol
- Recreational drugs (which? \_\_\_\_\_)  
(how much per week? \_\_\_\_\_)
- High pitched ringing in the ears
- Gall stones (past or present)
- Sexually transmitted disease  
(which? \_\_\_\_\_)

**EYES (Liver Function)**

- Itchy
- Bloodshot
- Hot
- Dry
- Watery
- Gritty
- Blurry vision
- Decreased night vision
- Near-sighted
- Far-sighted

**KIDNEY, URINARY BLADDER FUNCTION**

- Frequent cavities
- Easily broken bones
- Sore knees
- Weak knees
- Cold sensations in the knees
- Low back pain
- Memory problems
- Excessive hair loss
- Low-pitched ringing in the ears
- Kidney stones
- Bladder infections
- Wake during the night twice or more to urinate

**KIDNEY, URINARY BLADDER FUNCTION (cont.)**

- Lack of bladder control
- Fear
- Easily startled

- Strong odor
- Burning
- Painful
- Discharge
- Difficult
- Urgent
- Frequent

**URINATION**

- Normal color
- Dark yellow
- Clear
- Reddish
- Cloudy
- Scanty
- Profuse

**LIBIDO**

- Normal
- High
- Low
- Other symptoms: \_\_\_\_\_

**Women Only:**

Regular menstrual cycle?  YES  NO      Pregnant?  YES  NO

Number of pregnancies: \_\_\_\_\_ Number of children: \_\_\_\_\_ Age of 1st menstruation: \_\_\_\_\_

Age of menopause: \_\_\_\_\_ Average # of days of flow: \_\_\_\_\_ Average # of days of cycle: \_\_\_\_\_

	SEVERE	MODERATE	SLIGHT	NORMAL
Vaginal Discharge:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding between periods:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Do you experience any of the following pre-menstrual syndromes?

- |  |  |  |                                    |
|--|--|--|------------------------------------|
| <input type="checkbox"/> nausea                | <input type="checkbox"/> food cravings   | <input type="checkbox"/> depression              | <input type="checkbox"/> vomiting  |
| <input type="checkbox"/> headaches             | <input type="checkbox"/> irritability    | <input type="checkbox"/> water retention         | <input type="checkbox"/> migraines |
| <input type="checkbox"/> anxiety               | <input type="checkbox"/> breast swelling | <input type="checkbox"/> breast tenderness       |                                    |
| <input type="checkbox"/> other emotions: _____ |  | <input type="checkbox"/> dull pain, where? _____ |                                    |
| <input type="checkbox"/> other: _____          |  |  |                                    |

**Please fill out menstrual chart on following page.**

Please fill in the following menstrual chart (enter color)	Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7
Color (normal, bright red, pale, brown, rust, dark, purple, other)							
Amount of flow (normal, heavy, light)							
Pain/cramps (location, dull, sharp, other)							
Clots (large, small, black, purple, red, other)							
Vomiting (check if yes)							
Nausea (check if yes)							
Other							

**Men Only:**

	SEVERE	MODERATE	SLIGHT	NORMAL
Swollen testes:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Testicular pain:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Impotence:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Premature ejaculation:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Coldness/numbness in external genitalia:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**All patients — please fill out:**

Other comments: \_\_\_\_\_

Patient Signature: \_\_\_\_\_

Acupuncturist Signature: \_\_\_\_\_