

Health History Questionnaire

Date _____

Full Name _____ Age _____ Gender _____

Address _____ Height _____ Weight _____

_____ Date of birth _____

Home phone _____ Name of physician _____

Work phone _____ Clinic _____

Cell phone _____ Location _____

Emergency contact _____ Phone number _____

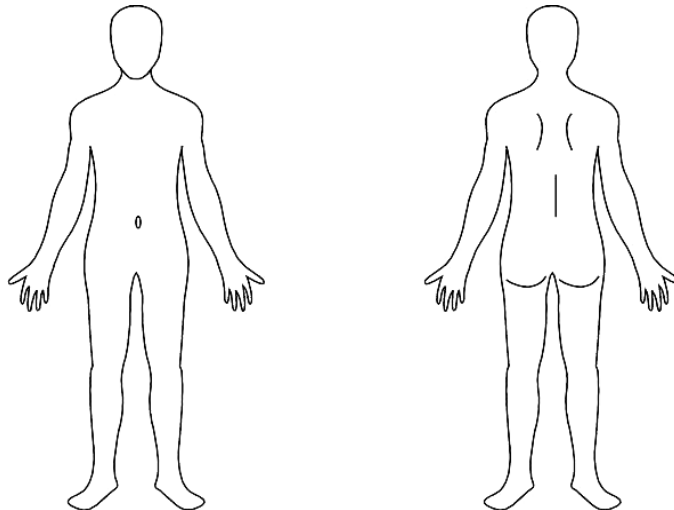
Who should we thank for referring you? _____

Had acupuncture before? _____ If so, where and when? _____

Please list the concerns that brought you here today:

Symptom	Date first noticed
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____

Please indicate where your symptoms are occurring:



What other treatments have you explored? _____

What medications are you currently taking? _____

What dietary supplements do you take regularly? _____

Please describe your typical diet: _____

How many cups of coffee, tea or other caffeinated beverage do you drink daily _____

How many alcoholic beverages do you drink weekly? _____

Are you a smoker? ____ If so, how many times per day do you use tobacco? _____

Do you exercise? ____ If so, please describe what you do: _____

Please describe any that apply:

	Your own history:	Your family's history:
Heart disease		
Cancer		
Hypertension		
Thyroid disorder		
Hepatitis		
Asthma/Allergies		
HIV/AIDS		
STDs		
Hereditary disorders		
Seizures		
Stroke		
Neurological disorders		
Other (please specify)		

Please describe any trauma or surgery you have had: _____

General

- Chills
- Fevers
- Sweat easily
- Night sweats
- Localized weakness
- Bleed or bruise easily
- Peculiar tastes or smells
- Strong thirst (cold / hot)
- Thirst, no desire to drink
- Fatigue
- Sudden energy drop
Time of day: _____
- Edema
Where: _____
- Poor sleeping
- Tremors
- Poor balance
- Cravings
- Change in appetite
- Poor appetite
- Weight change
Gain / Loss _____

Skin and Hair

- Rashes
 - Itching
 - Change in hair or skin
 - Ulcerations
 - Eczema
 - Oozing skin lesion
 - Hives
 - Pimples
 - Recent moles
 - Loss of hair
 - Dandruff
- Other hair or skin problems*

**Head, Eyes, Ears
Nose, and Throat**

- Dizziness
- Migraines
- Headaches
When: _____
Where: _____
- Facial pain
- Glasses
- Poor vision
- Night blindness
- Blurry vision

- Color blindness
 - Blind field
 - Spots in front of eyes
 - Eye pain
 - Eye strain
 - Cataracts
 - Eye Dryness
 - Excessive tearing
 - Discharge from eyes
 - Poor hearing
 - Ringing in ears
 - Earaches
 - Discharge from ear
 - Nose bleeds
 - Sinus congestion
 - Nasal drainage
 - Grinding teeth
 - Teeth problems
 - Jaw clicks
 - Concussions
 - Recurrent sore throats
 - Hoarseness
 - Sores on lips/tongue
- Other head / neck problems*

Cardiovascular

- High blood pressure
 - Low blood pressure
 - Chest discomfort/pain
 - Heart palpitations
 - Cold hands or feet
 - Swelling of hands
 - Swelling of feet
 - Blood clots
 - Fainting
 - Difficulty in breathing
- Other heart/blood vessel problems:* _____

Respiratory

- Cough
 - Asthma/wheezing
 - Difficulty in breathing when lying down
 - Phlegm *Color?* _____
 - Coughing blood
 - Pneumonia
 - Bronchitis
- Other lung problems:* _____

Gastrointestinal

- Bad breath
 - Nausea
 - Vomiting
 - Heartburn
 - Belching
 - Indigestion
 - Diarrhea
 - Constipation
 - Chronic laxative use
 - Blood in stools
 - Black stools
 - Abdominal pain/cramps
 - Gas
 - Rectal pain
 - Hemorrhoids
- Other stomach or intestinal problems:* _____

Genito-Urinary

- Pain on urination
 - Urgency to urinate
 - Frequent urination
 - Blood in urine
 - Decrease in flow
 - Dribbling
 - Kidney stones
 - Impotency
 - Change of sexual drive
 - Sores on genitals
- Do you wake to urinate?*
 Yes No
- How often?* _____
- What color is your urine?*

- Other genital or urinary system problems?* _____

**Pregnancy and
Gynecology**

- # of pregnancies:* _____
- # of births:* _____
- # premature births:* _____
- # of miscarriages:* _____
- # of abortions:* _____
- Age at first menses:* _____
- Length of full cycle:* _____
- Length of menses:* _____
- Last menses start date:* _____

- Heavy periods
 - Light periods
 - Painful periods
 - Irregular periods
 - Changes in body/psyche prior to menstruation
 - Clots
 - Vaginal discharge:
 - Menopause:
Age: _____
Year: _____
 - Postcoital bleeding
 - Vaginal sores
 - Breast lumps
 - Nipple discharge
- Do you practice birth control?*
 Yes No
- What type and for how long?*

Musculoskeletal

- Neck pain
 - Shoulder pain
 - Back pain
 - Elbow pain
 - Hand/wrist pain
 - Hip pain
 - Knee pain
 - Foot/ankle pain
 - Muscle pain
 - Muscle weakness
- Other pain?* _____

Neuropsychological

- Seizures
 - Areas of numbness
 - Weakness
 - Sleep disorder
 - Concussion
 - Violence potential
 - Vertigo
 - Lack of coordination
 - Bad temper
 - Depression
 - Easily stressed
 - Loss of balance
 - Poor memory
 - Anxiety
 - Substance abuse
- Have you ever been treated for emotional problems?*
 Yes No