HEALTH HISTORY QUESTIONNAIRE

All information is strictly confidential

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

I. General Patient Information

Date: ____/____/____; Age: _____ Date of Birth: ____/____/____ Place of Birth: _____

Name: _____

Address: _____

City, State, Zip Code: _____

Home Phone: _(_____)_____ Work Phone: (_____)_____

Cell Phone: _(_____)_____ E-mail address _____

Guardian (if under 18) or Emergency Contact:_____Relationship:_____

Emergency Contact Phone #_____

❑M ❑F Height: ____'____" Weight: _____lbs.

Occupation:_____Employer:_____

How did you hear about our clinic? _____

Other Physicians/Therapists seen for this condition? _____

Medications (if any): _____

_____

Prescribed by: _____

Treatment: _____

Results: _____

Supplements (if any vitamins, herbs, minerals, etc.) _____

_____

Major Complaint(s), in order of significance to you:

	Severe	Moderate	Slight	Normal	
1					
2	☐	☐	☐	☐	
3	☐	☐	☐	☐	
4	☐	☐	☐	☐	
5	☐	☐	☐	☐	
6	☐	☐	☐	☐	
7	☐	☐	☐	☐	
8	☐	☐	☐	☐	
9	☐	☐	☐	☐	
10	☐	☐	☐	☐	

How do these conditions impair your daily activities?_____

_____

_____

II. **Patient Medical History**

How was your childhood health?_____

Hospital Visits/Stays:_____

Recent tests: (please indicate test results and date below)

❑Physical ❑Cholesterol ❑Prostate ❑Blood (which?)
❑HIV/STD ❑Pap smear ❑Mammography ❑Other:_____

Test Results and Date:_____

Circle any you have had in the past:

❑Diabetes ❑Allergies ❑Glaucoma ❑Rheumatic Fever
❑Heart Disease ❑CVA (stroke) ❑Vein condition ❑Thyroid disorder
❑Asthma ❑Pneumonia ❑Tuberculosis ❑Emphysema
❑Jaundice ❑Gonorrhea ❑Mumps ❑Bleeding tendency
❑Syphilis ❑Measles ❑Chicken pox ❑Nervous disorder
❑Meningitis ❑HIV ❑Polio ❑Mononucleosis
❑Epilepsy ❑High fever ❑Hepatitis ❑Multiple Sclerosis
❑Paralysis ❑Cancer ❑Migraines ❑High blood pressure
❑other lung illnesses ❑other liver illnesses ❑other heart illnesses ❑other kidney illnesses
❑other:_____

Immunizations:_____

Surgeries:_____

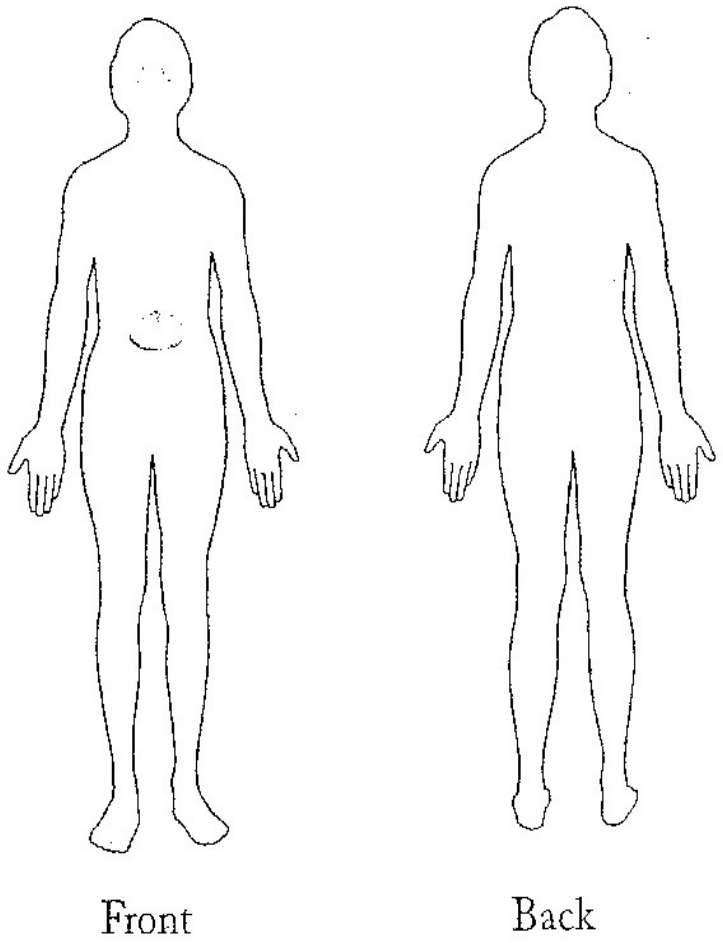
III. Patient Profile

Please clearly mark any areas of pain and any scars (please indicate which of the areas are scarred):

Is the pain:
❑Sharp ❑Burning ❑Aching
❑Cramping ❑Dull ❑Moving
❑Fixed Other:_____

Do the following lessen the pain?
❑Pressure ❑Cold ❑Heat
❑ Exercise ❑Other:_____

Do the following worsen the pain?
❑Pressure ❑Cold ❑Heat
❑Other:_____



Please check the following that currently pertain to you (if you have symptoms in the following categories, it indicates that you have a problem with that organ's function):

Overall Temperature (Kidney function):
❑Cold hands
❑Cold fingers
❑Cold feet
❑Cold toe
❑Sweaty hands
❑Sweaty feet
❑Hot body temperature (sensation)

❑Cold body temperature (sensation)
❑Afternoon flushes
❑Night sweats
❑Heat in the hands, feet, and chest
❑Hot flashes any time of the day
❑Thirsty
❑Perspire easily
❑Lack of perspiration
❑Take water to bed

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

Overall 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 un-refreshed
❑Drink coffee (# of cups per week: _____)

Lung function:
❑Nasal Discharge (Color: _____)
❑Cough
❑Nose Bleeds
❑Sinus Congestion
❑Dry mouth
❑Dry throat
❑Dry Nose
❑Dry Skin
❑Allergies (To what? _____)
❑Alternating fever and chills
❑Sneezing
❑Headache (Location: _____)
❑Overall achy feeling
❑Stiff neck

❑Stiff shoulders
❑Sore throat
❑Difficulty breathing
❑Smoke cigarettes (# of cigarettes per 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 (previously diagnosed, which organ? _____)
❑Easily bruised
❑Hemorrhoids
❑Pensive
❑Over-thinking
❑Worry

Spleen, Stomach, Large Intestine, Small Intestine function:
❑Loose
❑Constipated
❑Incomplete
❑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
❑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

Liver & Gallbladder 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 (What causes the stress? _____)
❑Skin rashes
❑Headache at the top of the head
❑Tingling sensation
❑Numbness
❑Muscle spasms
❑Muscle twitching
❑Muscle cramping
❑Seizures
❑Convulsions

Liver & Gallbladder Function Continued
❑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 (history or current)
❑Sexually transmitted disease (Which? _____)
Teeth Grinding at night or day

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 sensation 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
❑Lack of bladder control
❑Fear
❑Easily startled

Urination:
❑Normal color
❑Dark yellow
❑Clear
❑Reddish
❑Cloudy
❑Scanty
❑Profuse
❑Strong odor
❑Burning
❑Painful
❑Discharge
❑Difficult
❑Painful
❑Urgent
❑Frequent

Libido:
❑Normal
❑High
❑Low

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Male Patient's Section:

	Severe	Moderate	Slight	Normal
❑Swollen testes				
❑Testicular pain				
❑Impotence				
❑Premature ejaculation				
❑Feeling of coldness or numbness in external genitalia				
❑Other				

Female Patient's Section:

Regular menstrual cycle? ❑Y ❑N
Number of children:_____
Age of first menstruation:_____
Average number of days of flow:_____
❑Vaginal discharge

Pregnant? ❑Y ❑N
Number of pregnancies:_____
Age of menopause (if applicable):_____
Average number of days of entire cycle:_____
❑Bleeding between periods

Do you experience any of the following pre-menstrual syndrome symptoms?

❑nausea ❑vomiting ❑water retention ❑breast swelling
❑food cravings ❑headaches ❑migraines ❑breast tenderness
❑depression ❑irritability ❑anxiety ❑other emotions:_____
❑dull pain, where?_____ ❑sharp pain, where?_____

Please fill in the following menstrual chart:

	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							

Please list any doctors that you are currently seeing as a patient. It is important that we are all informed to your personal health. We will send your doctor an introduction letter and package on acupuncture and Chinese medicine. I feel it is extremely important anything I am able to do to better bring you into a balance and free of energy blockage, that you may live a life of good health.

List of Doctors:

Doctors Name	Address	Phone	Type of Doctor

Other Comments:_____

_____

_____

_____

Patient Signature:_____

Acupuncturist Signature:_____