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_____

Phone_____Alt Phone_____Email _____

Age_____Date of Birth_____Height_____Weight_____

Gender_____ Pronouns_____Marital Status_____

Education: □ Grammar School □ High School □ College □ Masters □ Doctorate

Occupation:_____Retired:_____Disabled:_____Unemployed:_____

Family Physician:_____Referred by:_____

Emergency Contact:_____Emergency Contact Relation to you:_____

Emergency Contact telephone:_____

Have you ever been treated by acupuncture or Oriental medicine before? □ Yes □ No

Main Problem 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:_____

How confident are you that Acupuncture and Chinese herbal medicine will be able to resolve the symptoms of your main complaint?
□ Not confident □ Slightly confident □ Moderately confident □ Confident □ Very confident

Secondary Complaints you would like us to help you with:_____

_____

_____

_____

Past Personal Medical History of Significant Illnesses: □ Asthma □ Allergies □ Diabetes

□ Cancer □ Stroke □ Heart disease □ High Blood Pressure □ Seizures □ Hepatitis

□ Rheumatic Fever □ Thyroid disease □ Other AutoImmune:_____ □ Other

_____

_____

Hospitalizations/Surgeries (including dates):_____

_____

_____

_____

Significant Trauma (auto accidents, falls, etc.):_____

_____

Allergies (drugs, chemicals, metals, foods):_____

_____

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, drugs, herbs, etc.):_____

_____

_____

Are there any areas of your life that you find stressful? Please describe:_____

_____

Do you have a regular exercise program? □ No □ Yes If yes, please 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? _____

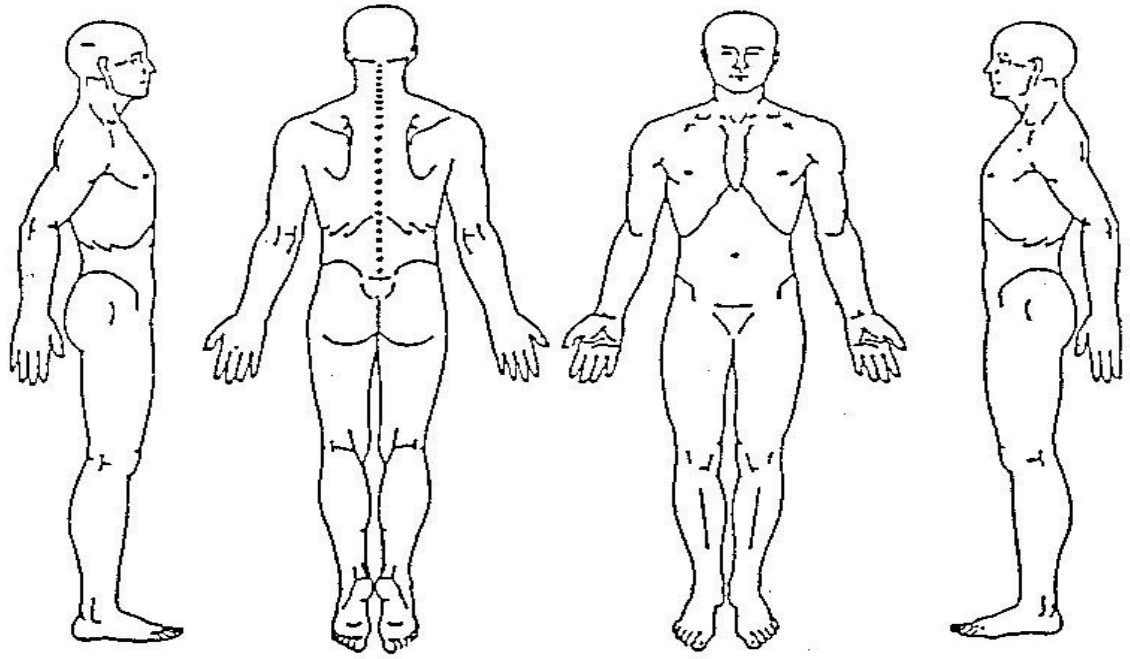
How many cups of caffeinated coffee, tea, or cola do you drink per week?_____

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:



Please check if you have had any of the following, particularly if in the last three months:

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?_____

REPRODUCTIVE & GYNECOLOGIC:

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? _____

MUSCULOSKELETAL:

□ Neck pain □ Rotator cuff □ Knee pain □ Foot/ankle pain

□ Muscle pain □ Muscle spasm □ 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)

NEUROLOGICAL & PSYCHOLOGICAL:

□ Seizures □ Dizziness □ Loss of balance □ Areas of numbness

□ Poor memory □ Concussion □ Poor coordination □ Bad temper

□ Anxiety □ Depression □ Easily susceptible to stress

□ 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.*

_____

_____

_____

_____

_____

_____

_____