HEALTH HISTORY QUESTIONNAIRE - All information is strictly confidential

General patient information

Date: ____/____/____

Name: ______________________________ E-mail Address: ______________________________

Address: ______________________________ City, State, Zip: ______________________________

Home Phone: (____) ______________________________ Work Phone: (____) ______________________________

Age: ______ Date of Birth: __________/__________/__________ Place of Birth: ______________________________

Guardian (if under 18): ______________________________

Gender: ☐M ☐F ☐Neutral Height: ____________________ Weight: ______________________________

Occupation: ______________________________

Employer: ______________________________

How did you hear about our office? ______________________________

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

1. ______________________________ 2. ______________________________

3. ______________________________ 4. ______________________________

5. ______________________________ 6. ______________________________

Do these condition impair your daily activities? ☐Yes ☐No

Patient Medical History

How was your childhood health? ______________________________

Hospitalization(s): ______________________________

Recent test: (Please indicate the test result and date below)

☐Physical ☐Cholesterol ☐Blood (Which?) Other:

____

Test Result and Date: ______________________________

Check 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
☐Measles	☐Chicken Pox	☐Nervous disorder	☐Mononucleosis
☐Meningitis	☐HIV	☐Polio	☐Multiple Sclerosis
☐Paralysis	☐High Fever	☐Hepatitis	☐High blood pressure
☐Other Lung illnesses	☐Cancer	☐Migraines	☐Other Kidney illnesses
☐Epilepsy	☐Other Liver illnesses	☐Other Hearth illnesses	

Physical Traumas: ____
Emotional Traumas: ____
Surgeries: ____
Immunization: ____

Family medical history

	You	Your Relative	Approx. Date		You	Your Relative	Approx. Date
Cancer	☐	☐	__________	Diabetes	☐	☐	__________
Hepatitis	☐	☐	__________	Heart Disease	☐	☐	__________
High Blood Pressure	☐	☐	__________	Seizures	☐	☐	__________
Rheumatic Fever	☐	☐	__________	Emotional Disorders	☐	☐	__________
Infectious Diseases	☐	☐	__________	Tuberculosis	☐	☐	__________

Please indicate any significant illnesses your or a blood relative (Grandparent, parent or sibling) have had:

STD

Sexually Transmitted Diseases: ☐Gonorrhea ☐Syphilis ☐AIDS ☐HPV ☐Chlamydia ☐Herpes Date
____

Medications

List any medication and supplements you are currently taking:

Medicine	Dosage	Reason	How long	Prescribed by	Date of last checkup

coffee/alcohol/tobacco

Please indicate the use and frequency of the following:

	Yes	No	How Much		Yes	No	How Much		Yes	No	How Much
Coffee/black tea	☐	☐	__________	Tobacco	☐	☐	__________	Water Intake	☐	☐	__________
Non-medical drugs	☐	☐	__________	Alcohol	☐	☐	__________	Soda pop	☐	☐	__________

How do you feel about the following areas of your life?

How do you FEEL about the following areas of your life?
Please check the appropriate boxes and indicate any problems you may be experiencing

	Great	Good	Fair	Poor	Bad	Your Comments
Significant						
Other	☐	☐	☐	☐	☐	______________________________
Family	☐	☐	☐	☐	☐	______________________________
Diet	☐	☐	☐	☐	☐	______________________________
Sex	☐	☐	☐	☐	☐	______________________________
Self	☐	☐	☐	☐	☐	______________________________
Work	☐	☐	☐	☐	☐	______________________________
Exercise	☐	☐	☐	☐	☐	______________________________
Spirituality	☐	☐	☐	☐	☐	______________________________

Diagnostic questions

1. TEMPERATURE

Body	___Hot	___Cold	STRESS
Hands	___Hot	___Cold	[1-10]
Sweat	___Hands	___Feet	____________
	___Chest	___Flush	____________

2. SLEEP

___Trouble falling asleep	___Wake earlier than norma
___Restless Sleep	___Wake earlier than norma
___Vivid dreams/nightmares	___Wake in middle of night

3. BOWEL MOVEMENTS

___Diarrhea	___Urgency	___ x day
___Loose	___Incomplete	___x week
___Formed	___Blood	___Mucous
___Constipation	___Undigested food	___Black tarry

4. DIET

	Servings a day
Red Meat	____________
Chicken/Fish/Eggs	____________
Dairy/Milk/Cheese	____________
Fruit	____________
Vegetables	____________
Whole Grains	____________
Nuts & Seeds	____________
Rice, Pasta, Bread	____________
Sweets	____________

5. URINATION

___Colorless/clear	___Urgency	___Cloudy
___Straw/normal	___Frequent	___Burning/pain
___Dark/concentrated	___Scanty	___Strong Odor
___Reddish	___Profuse	___Discharge

6. APPETITE/THIRST

___Eat breakfast	___Drink water
___No appetite	___No thirst
___Excessive appetite	___Excessive thirst
___Eat after 8:00 p.m.	___Drink after 8:00 p.m.

7. EXERCISE

___Cardio	___Weights
____Yoga	___Walking
____Tai-chi	___Other______________
____x a week	Hours per week_____

For women

Age of 1st period (menarche) _________ Are you pregnant? ☐Yes ☐No # of pregnancies ______________________________

Age of last period (menopause) _______ # of Live births _____ # of Abortions ______ # of Miscarriages__________________

Number of days between periods _____ Date of last Gynecologic exam __________ Pap smear __________________________

Number of days of flow ____________ Mammogram ________________ Bone Density Scan __________________________

Color of Flow ____________________ Results ____

Clots? ☐Yes ☐No Color __________ ____

Average number of pads you use per day: 1st day _____ 2nd day _____ 3rd day _____ 4th day _____ +day __________________

Have you been diagnosed with: ☐Fibroids ☐Fibrocystic breasts ☐Endometriosis ☐Ovarian Cysts ☐PID ☐other

Location of Pain: ☐Lower abdomen ☐Lower back ☐Thighs other ____

Name of Pain: (Please indicate before, during or after menses) Other Symptoms related to menses:

Cramping ___________	Stabbing ____________
Burning ____________	Aching ______________
Dull ______________	Bloating _____________
Consistent __________	Intermittent __________
Bearing down sensation ______________________	

☐Discharge	☐Vaginal dryness	☐Headache
☐Nausea	☐Constipation	☐Diarrhea
☐Swollen breasts	☐Mood swings	☐Ravenous appetite
☐Poor appetite	☐Hot flashes	☐Night sweats
☐Increased libido	☐Decreased libido	☐Insomnia

For men

Date of last prostate checkup ____________ PSA results ___________ Manual prostate exam results _________________________

Lab results ____

☐Prostate problems ☐Delayed stream ☐Dribbling ☐Incontinence ☐Retention of urine

☐Rectal dysfunction ☐Increased libido ☐Decreased libido ☐Premature ejaculation ☐Impotence

☐Back pain ☐Groin pain ☐Testicular pain Other _______________

Terms of Acceptance

Acupuncture is an effective form of health care that has evolved into a complete and holistic medical system. Acupuncturists and practitioners of Traditional Chinese Medicine (TCM) use this non-invasive healing modality to help millions of people get well and stay healthy.

When a patient seeks Acupuncture care and is accepted as a patient for such care, it is essential for both patient and Acupuncturist to be working toward the same objectives in order to prevent any confusion or disappointment.

The main objective of Acupuncture is to determine where there are imbalances in the body as they related to TCM. When the flow of Qi (the vital energy that flows throughout the body) is disrupted, illness and disease may occur. An imbalance in any of the 14 main Meridian channels causes an alteration in the flow of Qi through the body. This can result in a lessening of the body's innate ability to heal itself and express maximum health potential.

Once imbalance are detected, various treatment modalities may be employed to correct these imbalances. Any health condition(s) or disease(s) presented by the patient will be treated according to TCM only and treatment will related only to the quantity, quality and balance of Qi.

The ONLY practice objective is to detect and correct imbalances within Meridian channels using Acupuncture and TCM techniques.

Patients will be advised if a non-Acupuncture related or otherwise unusual finding is encountered during the course of an Acupuncture examination. If advice, diagnosis or treatment of those findings is desired, patients will be referred to a qualified health care professional.

have read fully understand the above statements.

All questions regarding the acupuncturist's objectives pertaining to my care in this office have been answered to my complete satisfaction. I therefore accept Acupuncture care under these terms.

Signature ____ Date ____