Health History Questionnaire
(Information For Your Acupuncturist)

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

General Patient Information:

Date: ___/____/____

Name:
____

Address:
____

Home Phone: ____________________Work Phone:
____

Cell: __________________________ Email Address:
____

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

Guardian (if under 18):
____

Gender: ☐M ☐F Height: ____' ____" Weight: ______lbs.

Social Security Number: ______-_____-________

Occupation: _________________________Employer:
____

How did you hear about our office?
____

Other physicians/therapists seen for this condition?
____

____

Medications: (if any)
____

Supplements: (if any vitamins, herbs, minerals, etc.):_________________________________

____

Major Complaint(s) in order of significance to you:	Severe	Moderate	Slight
1.			
2.			
3.			
4.			
5.			

How do these conditions impair you daily activities?

____

____

How was your childhood health?

____

Hospital Visits/Stays:

____

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

☐Physical ☐Cholesterol ☐Pap Smear ☐Blood (which?)

☐HIV/STD ☐Prostate ☐Mammography ☐Other ____________________

Test Results and Date: ____

Check any you have had in the past:

☐ Heart Disease ☐ Lung disease ☐ Glaucoma ☐ Diabetes

☐ CVA (stroke) ☐ Emphysema ☐ Thyroid disorder ☐ Chicken Pox

☐ Vein condition ☐ Asthma ☐ Tuberculosis ☐ Shingles

☐ Rheumatic Fever ☐ Pneumonia ☐ Jaundice ☐ Measles

☐ Bleeding Tendency ☐ Allergies ☐ Liver disease ☐ Mumps

☐ Heart disease ☐ Meningitis ☐ Gonorrhea ☐ Syphilis

☐ High blood pressure ☐ Hepatitis ☐Mononucleosis ☐ HIV

☐ Nervous System Disorder ☐ Cancer ☐ Multiple Sclerosis ☐ Polio

☐ Kidney disease ☐ Migraines ☐ High Fever ☐ Epilepsy

☐ Paralysis ☐ Other: ______________________

Immunizations: ____

Surgeries: ____

Family Member	Alive	Deceased	Present Health/Cause of death
Father			
Mother			
Spouse			
Sister			
Brother			
Child			
Child			
Child			
Child			

Where are you in the birth order: ___first, ___ last, ___ middle, ___ only

Check the following that have occurred in your blood relatives:

☐ Diabetes ☐ Cancer ☐ High Blood Pressure

☐ Allergies ☐ Tuberculosis ☐ Heart Disease

☐ Kidney Disease ☐ Obesity ☐ Bleeding Tendency

☐ Alcoholism ☐ Mental Illness ☐ Stroke

☐ Nervous System Disease ☐ Other __________________________

Current Condition

Is the pain: ☐Sharp Burning ☐ Aching ☐Cramping

☐Dull Moving ☐Fixed ☐ Other:________________

Do the following lessen the pain?

☐ Pressure ☐ Cold ☐ Heat ☐ Exercise

☐ Other: __________________________

Please check all conditions that currently pertain to you.

Overall Temperature (Kidney function)
__ Cold hands
__ Cold fingers
__ Cold feet
__Cold toes
__ Sweaty hands
__ Sweaty feet
__ Hot body temperature (sensation)
__ Cold body temperature (sensation)
__ Afternoon flushes
__ Night sweats
__ Heat in the hands, feed and chest
__ Hot flashes any time of the day
__Thirsty
__ Perspire easily
__ Lack of perspiration
__ Take water to bed

Overall blood (Liver, Spleen, Heart)
__ Seeing floating black spots
__ Dizziness

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 organs ___________)
__ Easily bruised
__ Hemorrhoids
__ Pensive
__ Over-thinking
__ Worry

Overall energy (Lung, Kidney function)
__ Shortness of Breath
__ Difficulty keeping eyes open in the day
__ General weakness
__ Easily catch cold
__ Low energy
__ Feel worse after exercise

Heart function:
__ Anxiety
__ Palpitations
__ Sores on the tip of the tongue
__ Restlessness
__ Mental confusion
__ Chest pain traveling to the shoulder
__ Frequent dreams
__ Wake un-refreshed
__ Drink coffee (# cups per day:___)

Spleen, Stomach, Large Intestine, Small Intestine function:
__ Loose stools
__ Constipated
__ Incomplete bowel movement
__ Diarrhea
__ Blood in the stools
__ Mucous in the stools
__ Undigested food in the stools

Lung function:
__ Nasal discharge (Color:___________)
__ Cough
__ Nose bleeds
__ Sinus congestion
__ Dry mouth
__ Dry throat
__ Dry nose

Dampness Trapped in the Body:
__ General sensation of heaviness in the body
__ Mental heaviness
__ Mental sluggishness
__ Mental fogginess
__ Swollen hands
__ Swollen feet

	__ Dry skin __ Allergies(List: ___________________) __ Alternating fever and chills __ Sneezing __ Headache Location:_______________) __ Overall achy feeling in the body __ Stiff neck __ Stiff shoulders __ Sore throat __ Difficulty breathing __ Smoke cigarettes (# of cigarettes per day:________) __ Sadness/Grief __ Melancholy **Eyes (Liver Function):** __ Itchy __ Bloodshot __ Hot __ Dry __ Watery __ Gritty __ Blurry vision __ Decrease night vision __ Near-sighted __ Far-sighted		__ 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
	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

	Liver, Gall Bladder Function:		Libido:
	Liver, Gall Bladder Function: __ Alternating diarrhea & 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		**Libido:** __ Normal __ High __ Low

Men Only:

__ swollen testes __ testicular pain __ impotence __ premature ejaculation
__ feeling of coldness or numbness in the external genitalia
other________________________________

Women Only:

Regular menstrual cycle? ___Y___N

Pregnant? ___Y___N

Number of children: ___

Number of pregnancies: ___

Age of first menstruation: ___

Age of menopause (if applicable):____

Average number of days of flow: ___

Average number of days of entire cycle: ___

Vaginal discharge ___ Y ___N

Bleeding between periods __Y __N

Please fill in the following menstrual chart:

Day	1	2	3	4	5	6	7
Color: Normal, bright red, pale, brown, rust, dark, purple							
Amount of flow: normal, heavy, light							
Pain/cramps: location, sharp, dull							
Clots: large, small, black, purple, red, other							
Vomiting							
Nausea							
Headache							
Other							