Health History Questionnaire

Information for your Acupuncturist

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

I. General Patient Information Date: ____/____/____

Name: ______________________________

Address: ______________________ City: ______________

State: __________ Zip: __________ Home Phone: (_____) ______________

Work Phone: (_____) ______________ Cell :(_____) ______________

Email: ______________________________

Date of Birth: _____/_____/_____ Age: ______ Place of Birth: ______________

Marital Status: ______________ Height: ___'____" Weight:____ lbs

Partner/Spouse: ______________ Years married: ______________

Children: ______________________________

____

Pets: ______________________________

Occupation: ______________________ Employer: ______________

II. Medical History

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

	Severe	Moderate	Slight	
1.	☐	☐	☐	______________
2.	☐	☐	☐	______________
3.	☐	☐	☐	______________
4.	☐	☐	☐	______________
5.	☐	☐	☐	______________
6.	☐	☐	☐	______________
7.	☐	☐	☐	______________
8.	☐	☐	☐	______________

How do these conditions impair your daily activities? ______________

____

What treatments have you tried for these conditions? ______________

____

What result have you seen? ______________________________

How was your childhood health? ______________________________
Immunizations: ______________________________
Surgeries/Hospitalizations: ______________________________
____
Scars: ______________________________
Trauma (physical or emotional): ______________________________
____

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

- ☐ Physical ☐ Cholesterol ☐ Other blood (which?) ☐ Prostate
- ☐ HIV/STD ☐ Pap smear ☐ Mammography ☐ Other

Test Results and Date: ______________________________

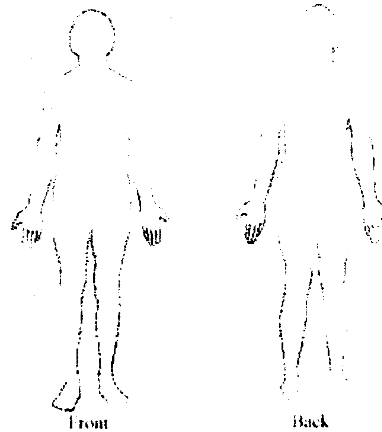
Check any you have had in the past:

☐ Allergies	☐ Epilepsy	☐ Cancer
☐ Asthma	☐ Paralysis	☐ Glaucoma
☐ Bronchitis	☐ Stroke	☐ Lupus
☐ Pneumonia	☐ Migraines	☐ Scleroderma
☐ Emphysema	☐ Vein Condition	☐ Ulcerative Colitis
☐ Diabetes	☐ Multiple Sclerosis	☐ Crohns Disease
☐ Thyroid Disorder	☐ Parkinsons	☐ Kidney Stones
☐ Heart Disease	☐ Fibromyalgia	☐ Gall Stones
☐ Hypertension	☐ Measles	☐ Other Neurologic disorder
☐ Hepatitis	☐ Mumps	☐ Other Hormone disorder
☐ Pancreatitis	☐ Mononucleosis	☐ Other kidney disorder
☐ Meningitis	☐ Chicken Pox	☐ Other lung disorder
☐ HIV	☐ Polio	☐ Other liver disorder
☐ Syphilis	☐ Tuberculosis	☐ Other pancreas/spleen disorder
☐ Gonorrhea	☐ Rheumatic Fever	☐ Other: ______________

III. Family History

	Age	Alive	Deceased	Health History
Father	___	☐	☐	______________
Mother	___	☐	☐	______________
Brother	___	☐	☐	______________
Brother	___	☐	☐	______________
Brother	___	☐	☐	______________
Sister	___	☐	☐	______________
Sister	___	☐	☐	______________
Sister	___	☐	☐	______________
Child	___	☐	☐	______________
Child	___	☐	☐	______________
Child	___	☐	☐	______________

IV. Patient Profile
Please mark any areas of pain or scars:



Is the pain:
- ☐ Sharp ☐ Cramping ☐ Aching
- ☐ Dull ☐ Moving ☐ Tingling
- ☐ Burning ☐ Other: ______________

Do the following lessen the pain?:
- ☐ Pressure ☐ Heat ☐ Cold
- ☐ Exercise ☐ Rest ☐ Other: ____

Do the following worsen the pain?:
- ☐ Pressure ☐ Heat ☐ Cold
- ☐ Exercise ☐ Rest ☐ Other: ____

Overall Energy (Lung, Kidney function):
- ☐ Fatigue during the day
- ☐ General weakness
- ☐ Easily catch colds
- ☐ Shortness of breath
- ☐ Feel worse after exercise
- ☐ Prolonged recovery from illness
- ☐ Aversion to talking
- ☐ Pasty pale complexion
- ☐ Exercise: What? _____ How Often? _____

Overall Temperature (Kidney function):
- ☐ Cold hands/feet
- ☐ Sweaty hands/feet
- ☐ Feel generally more Hot
- ☐ Feel generally more Cold
- ☐ Afternoon flushes
- ☐ Red cheeks at times
- ☐ Hot flashes any time of day
- ☐ Night sweats
- ☐ Heat in hands, feet, and chest
- ☐ Thirsty and drink in gulps
- ☐ Thirst but no desire to drink
- ☐ Thirst but take sips
- ☐ Take water to bed
- ☐ Perspire easily – where? _____
- ☐ Perspire w/ rest
- ☐ Lack of perspiration

Heart function:
- ☐ Palpitations
- ☐ Anxiety
- ☐ Panic attacks
- ☐ Emotional Sensitivity
- ☐ Restlessness
- ☐ Easily startled
- ☐ Trouble falling asleep
- ☐ Dull or glazed eyes
- ☐ Chest pain or discomfort
- ☐ Sores on tip of tongue
- ☐ Frequent dreams
- ☐ Ever fainted

Lung function:
- ☐ Nasal discharge (Color: _______)
- ☐ Sinus congestion
- ☐ Allergies (To: ______________)
- ☐ Nose bleeds
- ☐ Dry cough
- ☐ Productive cough (Color:_______)
- ☐ Dry mouth, nose, throat, skin
- ☐ Sore throat
- ☐ Overall achy feeling
- ☐ Alternating chills & fever
- ☐ Trouble breathing
- ☐ Asthma – trouble w/exhaling
- ☐ Sadness, melancholy, grief

Spleen function:

☐ Low appetite
☐ Abrupt weight gain
☐ Abrupt weight loss
☐ Abdominal bloating
☐ Abdominal gas
☐ Gurgling noise in stomach
☐ Fatigue after eating
☐ Prolapsed organs (bladder, vagina)
☐ Hernias
☐ Hemorrhoids
☐ Easily bruised
☐ Pensive
☐ Over-thinking, obsess
☐ Worry
☐ Difficulty focusing, distractible
☐ Overwhelmed by details

Large and Small Intestine function:

☐ Bowel movement: (#/day___, or #/wk___)
☐ Loose
☐ Diarrhea
☐ Burning
☐ Lack of control (incontinence)
☐ Constipation
☐ Hard dry stool
☐ Incomplete
☐ Blood in stool
☐ Mucous in stool
☐ Undigested food in stool
☐ Cramping and pain
☐ Gas/flatus
☐ Blood sugar variable
☐ Food sensitivity / intolerance:________

____

Dampness trapped in the body:

☐ General sensation of heaviness
☐ Mental heaviness, sluggishness, fogginess
☐ Swollen hands, feet, joints
☐ Chest congestion
☐ Sinus congestion
☐ Nausea
☐ Snoring

Stomach function:

☐ Large appetite
☐ Mouth (canker) sores
☐ Bad breath
☐ Bleeding, swollen or painful gums
☐ Burning sensation after eating
☐ Heartburn, acid regurg, GERD
☐ Ulcer (diagnosed in past)
☐ Belching
☐ Hiccoughs
☐ Stomach pain
☐ Nausea/Vomiting
☐ Anorexia
☐ Bulimia
☐ Headache over forehead
☐ Aversion to strong odors or flavors

Liver/Gall Bladder function:

☐ Alternating diarrhea / constipation
☐ Tight sensation in chest or under ribs
☐ Bitter taste in mouth
☐ Lump in throat / trouble swallowing
☐ Itching
☐ Skin rashes
☐ Muscle spasm, twitching, cramping
☐ Tingling sensation
☐ Numbness
☐ Migraines
☐ Headaches on top or side of head
☐ Neck and shoulder tension
☐ Seizures or stroke
☐ Alcohol (# drinks___ /day / week / month)
☐ Recreational drug history or current use
What:________________________
How often: ____________________
☐ Smoke (# cigs___ packs ___ / day /wk)
started ____ (yr) quit ____ (yr)
☐ Medications: (Name, dosage, for what)

____
____
____
____
____
____

Liver function (cont'd):

- ☐ Eyes bloodshot, hot, dry, painful, gritty
- ☐ Watery eyes
- ☐ Discharge from eyes
- ☐ Conjunctivitis
- ☐ Blurred vision
- ☐ Decreased night vision
- ☐ Cataracts
- ☐ Macular degeneration
- ☐ Glasses (what age:_____)
- ☐ Anger easily
- ☐ Frustration, irritability
- ☐ Depression
- ☐ Unable to adapt to stress
- ☐ PMS
- ☐ High pitched ringing in ears

Kidney and Bladder function:

- ☐ Kidney stones
- ☐ Urinary tract infections (UTI)
- ☐ Wake during the night to void
- ☐ Low back pain
- ☐ Cold knees
- ☐ Weak, sore knees
- ☐ Frequent cavities
- ☐ Broken bones
- ☐ Memory problems
- ☐ Excess hair loss
- ☐ Early graying of hair
- ☐ Decreased range of motion
- ☐ Repeat miscarriage
- ☐ Need excessive sleep
- ☐ Apathy or decreased motivation
- ☐ Easily defeated or disgruntled
- ☐ Dark circles under eyes
- ☐Asthma trouble w/ inhaling
- ☐Phobia or fears
- ☐ Low pitched ringing in ears
- ☐ Hearing loss or trouble hearing
- ☐ Urgency or frequent urination
- ☐ Difficult or incomplete urination
- ☐ Lack of bladder control
- ☐ Stress incontinence
- ☐ Crave caffeine & stimulants
- ☐ #cups coffee/day___ or week___
- ☐ Water intake: #glasses/day_____

Sexual function:

- ☐ Normal libido
- ☐ High libido
- ☐ Low libido
- ☐ Difficulty with arousal or climax

Men only:

- ☐ Premature ejaculation
- ☐ Impotence
- ☐ Swollen testicles
- ☐ Testicular pain
- ☐ Feeling of coldness in genitals
- ☐ Prostate swelling or prostatitis
- ☐ Elevated PSH

Blood (liver, spleen, heart function):

- ☐ Dizziness, light headed
- ☐ See floating spots
- ☐ Weak vision
- ☐ Dry eyes, hair, nails, skin
- ☐ Dry mucous membranes
- ☐ Thin hair
- ☐ Pale sallow complexion
- ☐ Restless fatigue
- ☐ Anxious sleep
- ☐ Emotional sensitivity
- ☐ Itchy skin
- ☐ Muscle cramps
- ☐ Dry hard stool
- ☐ Anemia
- ☐ Infertility
- ☐ Lack of semen
- ☐ Miscarriage history
- ☐ Lack of breast milk
- ☐ Postpartum weakness
- ☐ Postpartum depression
- ☐ Poor skin healing
- ☐ Decrease flexibility
- ☐ Poor concentration

Women only:

Regular menses? ☐ Y ☐ N
Pregnant? ☐ Y ☐ N
Number pregnancies: _____
Number miscarriages/abortions: ____
Age of first menses: ____
Number of Days of flow: ____
Number of Days of entire cycle: ____
☐ Bleeding between periods
☐ Endometriosis☐ Ovarian Cysts

Birth Control method: ________________
☐ Do you have any of these PMS symptoms
☐ Nausea ☐ Vomiting ☐ Food cravings
☐ Headaches ☐ Migraines ☐ Bloating
☐ Breast tenderness ☐ Breast swelling
☐ Irritability ☐ Depression ☐ Anxiety
☐ Cramping☐ Other: ______________
☐ Vaginal discharge: (Color: _________)
☐ Fibroids

☐ Complications with pregnancies: ____

____

☐ Vaginal delivery (#: ______) ☐ C-sections (#: _____) ☐ Breastfed
☐ Postpartum complications: ____

____

Please fill in the following menstrual chart:

	Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7
Color (red, bright, pale, brown, rust, purple)							
Amount (heavy, mod, light, spotting)							
Pain/cramps (dull, sharp)							
Clots (lrg, sml, red, black)							
Vomiting (V), Nausea (N)							
Headache or Migraine							
Other							

Other comments: ____

____

____

Patient signature: ____