

# HEALTH HISTORY QUESTIONNAIRE

Information for your Acupuncturist

*Important:* 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.

*All information is strictly confidential.*

## General Patient Information

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Postal Code: \_\_\_\_\_

Home Phone: (\_\_\_\_) \_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_\_

Cell: Phone: (\_\_\_\_) \_\_\_\_\_ E-Mail: \_\_\_\_\_

Age: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Marital Status:   M     S     D     W  

In Case of Emergency, Contact: \_\_\_\_\_ Phone No.: \_\_\_\_\_

Guardian (if under 18): \_\_\_\_\_

Gender:  M  F Height: \_\_\_\_' \_\_\_\_" Weight: \_\_\_\_\_ lbs. Soc. Sec. #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

How did you hear about our office? \_\_\_\_\_

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

1. \_\_\_\_\_ 4. \_\_\_\_\_

2. \_\_\_\_\_ 5. \_\_\_\_\_

3. \_\_\_\_\_ Additional: \_\_\_\_\_

How do these conditions impair your daily activities? \_\_\_\_\_

\_\_\_\_\_

# HEALTH HISTORY QUESTIONNAIRE

## 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: \_\_\_\_\_

Check any you have had in the past:

- |                                               |                                                |                                                |                                               |
|-----------------------------------------------|------------------------------------------------|------------------------------------------------|-----------------------------------------------|
| <input type="checkbox"/> Diabetes             | <input type="checkbox"/> Allergies             | <input type="checkbox"/> Glaucoma              | <input type="checkbox"/> Rheumatic Fever      |
| <input type="checkbox"/> Heart Disease        | <input type="checkbox"/> CVA (stroke)          | <input type="checkbox"/> Vein condition        | <input type="checkbox"/> Thyroid disorder     |
| <input type="checkbox"/> Asthma               | <input type="checkbox"/> Pneumonia             | <input type="checkbox"/> Tuberculosis          | <input type="checkbox"/> Emphysema            |
| <input type="checkbox"/> Jaundice             | <input type="checkbox"/> Gonorrhea             | <input type="checkbox"/> Mumps                 | <input type="checkbox"/> Bleeding tendency    |
| <input type="checkbox"/> Syphilis             | <input type="checkbox"/> Measles               | <input type="checkbox"/> Chicken pox           | <input type="checkbox"/> Nervous disorder     |
| <input type="checkbox"/> Meningitis           | <input type="checkbox"/> HIV                   | <input type="checkbox"/> Polio                 | <input type="checkbox"/> Mononucleosis        |
| <input type="checkbox"/> Epilepsy             | <input type="checkbox"/> High fever            | <input type="checkbox"/> Hepatitis             | <input type="checkbox"/> Multiple Sclerosis   |
| <input type="checkbox"/> Paralysis            | <input type="checkbox"/> Cancer                | <input type="checkbox"/> Migraines             | <input type="checkbox"/> High blood pressure  |
| <input type="checkbox"/> Other lung illnesses | <input type="checkbox"/> Other liver illnesses | <input type="checkbox"/> Other heart illnesses | <input type="checkbox"/> Other kidney illness |

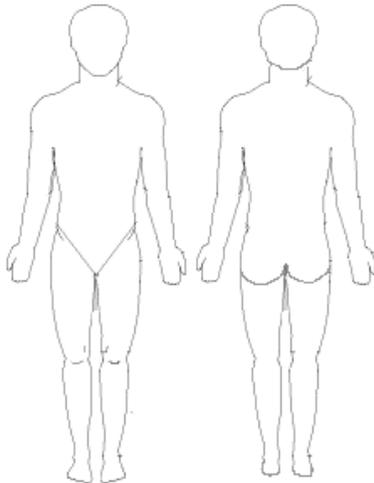
Other:

Immunizations: \_\_\_\_\_

Surgeries: \_\_\_\_\_

## III. Patient Profile

After printing, please clearly mark any areas of pain and any scars:



Is the pain:

- |                                   |                                  |                                 |
|-----------------------------------|----------------------------------|---------------------------------|
| Sharp <input type="checkbox"/>    | Burning <input type="checkbox"/> | Aching <input type="checkbox"/> |
| Cramping <input type="checkbox"/> | Dull <input type="checkbox"/>    | Moving <input type="checkbox"/> |
| Fixed <input type="checkbox"/>    | Other: <input type="checkbox"/>  |                                 |

Does the following lessen the pain?

- |                                   |                                 |                               |
|-----------------------------------|---------------------------------|-------------------------------|
| Pressure <input type="checkbox"/> | Cold <input type="checkbox"/>   | Heat <input type="checkbox"/> |
| Exercise <input type="checkbox"/> | Other: <input type="checkbox"/> |                               |

Does the following worsen the pain?

- |                                   |                               |                               |
|-----------------------------------|-------------------------------|-------------------------------|
| Pressure <input type="checkbox"/> | Cold <input type="checkbox"/> | Heat <input type="checkbox"/> |
| Other: <input type="checkbox"/>   |                               |                               |

## HEALTH HISTORY QUESTIONNAIRE

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):

- |                                                            |                                                             |
|------------------------------------------------------------|-------------------------------------------------------------|
| <input type="checkbox"/> Cold hands                        | <input type="checkbox"/> Afternoon flushes                  |
| <input type="checkbox"/> Cold fingers                      | <input type="checkbox"/> Night sweats                       |
| <input type="checkbox"/> Cold feet                         | <input type="checkbox"/> Heat in the hands, feet, and chest |
| <input type="checkbox"/> Cold toes                         | <input type="checkbox"/> Hot flashes any time of the day    |
| <input type="checkbox"/> Sweaty hands                      | <input type="checkbox"/> Thirsty                            |
| <input type="checkbox"/> Sweaty feet                       | <input type="checkbox"/> Perspire easily                    |
| <input type="checkbox"/> Hot body temperature (sensation)  | <input type="checkbox"/> Lack of perspiration               |
| <input type="checkbox"/> Cold body temperature (sensation) | <input type="checkbox"/> Take water to bed                  |

### Overall energy (Lung, Kidney function):

- |                                                                      |                                                    |
|----------------------------------------------------------------------|----------------------------------------------------|
| <input type="checkbox"/> Shortness of breath                         | <input type="checkbox"/> Easily catch colds        |
| <input type="checkbox"/> Difficulty keeping eyes open in the daytime | <input type="checkbox"/> Low energy                |
| <input type="checkbox"/> General weakness                            | <input type="checkbox"/> Feel worse after exercise |

### Overall blood (Liver, Spleen, Heart function):

- |                                    |                                                   |
|------------------------------------|---------------------------------------------------|
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> See floating black spots |
|------------------------------------|---------------------------------------------------|

### Heart function:

- |                                                                   |                                                           |
|-------------------------------------------------------------------|-----------------------------------------------------------|
| <input type="checkbox"/> Palpitations                             | <input type="checkbox"/> Night sweats                     |
| <input type="checkbox"/> Anxiety                                  | <input type="checkbox"/> Chest pain traveling to shoulder |
| <input type="checkbox"/> Sores on the tip of the tongue           | <input type="checkbox"/> Frequent dreams                  |
| <input type="checkbox"/> Restlessness                             | <input type="checkbox"/> Wake unrefreshed                 |
| <input type="checkbox"/> Mental confusion                         |                                                           |
| <input type="checkbox"/> Drink Coffee (# of cups per week: _____) |                                                           |

## HEALTH HISTORY QUESTIONNAIRE

### Lung function:

- |                                                            |                                                                               |
|------------------------------------------------------------|-------------------------------------------------------------------------------|
| <input type="checkbox"/> Nasal Discharge<br>(Color: _____) | <input type="checkbox"/> Smoke cigarettes (# of cigarettes<br>per day: _____) |
| <input type="checkbox"/> Cough                             | <input type="checkbox"/> Overall achy feeling in the body                     |
| <input type="checkbox"/> Nose Bleeds                       | <input type="checkbox"/> Stiff neck                                           |
| <input type="checkbox"/> Sinus Congestion                  | <input type="checkbox"/> Stiff shoulders                                      |
| <input type="checkbox"/> Dry mouth                         | <input type="checkbox"/> Sore throat                                          |
| <input type="checkbox"/> Dry throat                        | <input type="checkbox"/> Difficulty breathing                                 |
| <input type="checkbox"/> Dry Nose                          | <input type="checkbox"/> Sadness                                              |
| <input type="checkbox"/> Dry Skin                          | <input type="checkbox"/> Melancholy                                           |
| <input type="checkbox"/> Allergies (To what?:<br>_____)    | <input type="checkbox"/> Headache (Location:<br>_____)                        |
| <input type="checkbox"/> Alternating fever and chills      | <input type="checkbox"/> Sneezing                                             |

### Spleen function:

- |                                                        |                                                                                         |
|--------------------------------------------------------|-----------------------------------------------------------------------------------------|
| <input type="checkbox"/> Low appetite                  | <input type="checkbox"/> Prolapsed organs (previously diagnosed, which<br>organ? _____) |
| <input type="checkbox"/> Abrupt weight gain            | <input type="checkbox"/> Easily bruised                                                 |
| <input type="checkbox"/> Abdominal bloating            | <input type="checkbox"/> Hemorrhoids                                                    |
| <input type="checkbox"/> Abdominal gas                 | <input type="checkbox"/> Pensive                                                        |
| <input type="checkbox"/> Gurgling noise in the stomach | <input type="checkbox"/> Over-thinking                                                  |
| <input type="checkbox"/> Fatigue after eating          | <input type="checkbox"/> Worry                                                          |

### Spleen, Stomach, Large Intestine, Small Intestine function:

- |                                      |                                          |
|--------------------------------------|------------------------------------------|
| <input type="checkbox"/> Loose       | <input type="checkbox"/> Diarrhea        |
| <input type="checkbox"/> Constipated | <input type="checkbox"/> Blood in stools |
| <input type="checkbox"/> Incomplete  |                                          |

### Spleen, Stomach, Large Intestine, Small Intestine function:

- |                                           |                                                    |
|-------------------------------------------|----------------------------------------------------|
| <input type="checkbox"/> Mucous in stools | <input type="checkbox"/> Undigested food in stools |
|-------------------------------------------|----------------------------------------------------|

## HEALTH HISTORY QUESTIONNAIRE

### Dampness trapped in the body:

- |                                                                     |                                           |
|---------------------------------------------------------------------|-------------------------------------------|
| <input type="checkbox"/> General sensation of heaviness in the body | <input type="checkbox"/> Swollen feet     |
| <input type="checkbox"/> Mental heaviness                           | <input type="checkbox"/> Swollen joints   |
| <input type="checkbox"/> Mental sluggishness                        | <input type="checkbox"/> Chest congestion |
| <input type="checkbox"/> Mental fogginess                           | <input type="checkbox"/> Nausea           |
| <input type="checkbox"/> Swollen hands                              | <input type="checkbox"/> Snoring          |

### Stomach function:

- |                                                            |                                             |
|------------------------------------------------------------|---------------------------------------------|
| <input type="checkbox"/> Burning sensation after eating    | <input type="checkbox"/> Acid regurgitation |
| <input type="checkbox"/> Large appetite                    | <input type="checkbox"/> Ulcer (diagnosed)  |
| <input type="checkbox"/> Bad breath                        | <input type="checkbox"/> Belching           |
| <input type="checkbox"/> Mouth (canker) sores              | <input type="checkbox"/> Hiccoughs          |
| <input type="checkbox"/> Bleeding, swollen or painful gums | <input type="checkbox"/> Stomach pain       |
| <input type="checkbox"/> Heartburn                         | <input type="checkbox"/> Vomiting           |

### Liver, Gall Bladder function:

- |                                                                |                                                                                                     |
|----------------------------------------------------------------|-----------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> Alternating diarrhea and constipation | <input type="checkbox"/> Depression                                                                 |
| <input type="checkbox"/> Chest pain                            | <input type="checkbox"/> Irritability                                                               |
| <input type="checkbox"/> Tight sensation in the chest          | <input type="checkbox"/> Frequently unable to adapt to stress<br>(What causes the stress?<br>_____) |
| <input type="checkbox"/> Bitter taste in the mouth             | <input type="checkbox"/> Skin rashes                                                                |
| <input type="checkbox"/> Anger easily                          | <input type="checkbox"/> Headache at the top of the head                                            |
| <input type="checkbox"/> Frustration                           | <input type="checkbox"/> Tingling sensation                                                         |

## HEALTH HISTORY QUESTIONNAIRE

### Liver, Gall Bladder function:

- |                                             |                                                                                            |
|---------------------------------------------|--------------------------------------------------------------------------------------------|
| <input type="checkbox"/> Numbness           | <input type="checkbox"/> Limited Range-of-Motion, Neck                                     |
| <input type="checkbox"/> Muscle spasms      | <input type="checkbox"/> Shoulder tension                                                  |
| <input type="checkbox"/> Muscle twitching   | <input type="checkbox"/> Limited Range-of-Motion, Shoulder                                 |
| <input type="checkbox"/> Muscle cramping    | <input type="checkbox"/> Drink alcohol                                                     |
| <input type="checkbox"/> Seizures           | <input type="checkbox"/> Recreational drugs<br>(Which? _____,<br>How much per week? _____) |
| <input type="checkbox"/> Convulsions        | <input type="checkbox"/> High-pitched ringing in the ears                                  |
| <input type="checkbox"/> Lump in the throat | <input type="checkbox"/> Gall stones (history or current)                                  |
| <input type="checkbox"/> Neck tension       | <input type="checkbox"/> Sexually transmitted disease<br>(Which? _____)                    |

### Eyes (Liver function):

- |                                    |                                                 |
|------------------------------------|-------------------------------------------------|
| <input type="checkbox"/> Itchy     | <input type="checkbox"/> Gritty                 |
| <input type="checkbox"/> Bloodshot | <input type="checkbox"/> Blurry vision          |
| <input type="checkbox"/> Hot       | <input type="checkbox"/> Decreased night vision |
| <input type="checkbox"/> Dry       | <input type="checkbox"/> Near-sighted           |
| <input type="checkbox"/> Watery    | <input type="checkbox"/> Far-sighted            |

### Kidney, Urinary Bladder function:

- |                                                      |                                                                         |
|------------------------------------------------------|-------------------------------------------------------------------------|
| <input type="checkbox"/> Frequent cavities           | <input type="checkbox"/> Memory problems                                |
| <input type="checkbox"/> Easily broken bones         | <input type="checkbox"/> Excessive hair loss                            |
| <input type="checkbox"/> Sore knees                  | <input type="checkbox"/> Low-pitched ringing in the ears                |
| <input type="checkbox"/> Weak knees                  | <input type="checkbox"/> Kidney stones                                  |
| <input type="checkbox"/> Cold sensation in the knees | <input type="checkbox"/> Bladder infections                             |
| <input type="checkbox"/> Low back pain               | <input type="checkbox"/> Wake during the night twice or more to urinate |

### Kidney, Urinary Bladder function:

- |                                                  |                                          |
|--------------------------------------------------|------------------------------------------|
| <input type="checkbox"/> Lack of bladder control | <input type="checkbox"/> Easily startled |
| <input type="checkbox"/> Fear                    |                                          |

## HEALTH HISTORY QUESTIONNAIRE

### Urination:

- |                                       |                                    |
|---------------------------------------|------------------------------------|
| <input type="checkbox"/> Normal color | <input type="checkbox"/> Burning   |
| <input type="checkbox"/> Dark yellow  | <input type="checkbox"/> Painful   |
| <input type="checkbox"/> Clear        | <input type="checkbox"/> Discharge |
| <input type="checkbox"/> Reddish      | <input type="checkbox"/> Difficult |
| <input type="checkbox"/> Cloudy       | <input type="checkbox"/> Painful   |
| <input type="checkbox"/> Scanty       | <input type="checkbox"/> Urgent    |
| <input type="checkbox"/> Profuse      | <input type="checkbox"/> Frequent  |
| <input type="checkbox"/> Strong odor  |                                    |

### Libido:

- |                                 |                               |
|---------------------------------|-------------------------------|
| <input type="checkbox"/> Normal | <input type="checkbox"/> High |
| <input type="checkbox"/> Low    |                               |

## HEALTH HISTORY QUESTIONNAIRE

*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       Bleeding between periods

Do you experience any of the following pre-menstrual syndromes?

- Nausea                       Vomiting                       Water Retention               Breast Swelling  
 Food Cravings               Headaches                       Migraines                       Breast Tenderness  
 Depression                       Irritability                       Anxiety                       Other  
 Dull Pain, where? \_\_\_\_\_      Emotions: \_\_\_\_\_  
 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							

## HEALTH HISTORY QUESTIONNAIRE

*Men only:*

- |                                                                                |                                                |
|--------------------------------------------------------------------------------|------------------------------------------------|
| <input type="checkbox"/> Swollen testes                                        | <input type="checkbox"/> Testicular pain       |
| <input type="checkbox"/> Impotence                                             | <input type="checkbox"/> Premature ejaculation |
| <input type="checkbox"/> Feeling of coldness or numbness in external genitalia |                                                |
| Other _____                                                                    |                                                |

*All please fill out:*

Other Comments: \_\_\_\_\_  
\_\_\_\_\_

Patient Signature: \_\_\_\_\_

Acupuncturist Signature: \_\_\_\_\_