HEALTH HISTORY QUESTIONNAIRE

*Please help me 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 my attention that is not asked on this form, please note it in the Comments section. **Thanks***

NAME: _____ PHONE: H-_____ W- _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

AGE: _____ DATE OF BIRTH: _____ PLACE OF BIRTH: _____

E-MAIL:_____ News Letter Opt Out ☐ HEIGHT: _____ WEIGHT: _____

EMPLOYER NAME: _____ OCCUPATION: _____

FAMILY PHYSICIAN: _____ REFERRED BY: _____

IN EMERGENCY, NOTIFY: _____ PHONE: _____

HAVE YOU BEEN TREATED BY ACUPUNCTURE OR ORIENTAL MEDICINE BEORE? YES___ NO___

Main problem(s) you would like help with: _____

How long ago did this problem begin (be specific): _____

To what extent does this problem interfere with your daily activities (work, sleep, sex): _____

Have you been given a diagnosis for this problem? If so, what: _____

What kinds of treatments have you tried: _____

Past Medical History (please include date): Cancer _____ Diabetes _____

Hepatitis _____ High Blood Pressure _____ Heart Disease _____

Rheumatic Fever _____ Thyroid Disease _____ Seizures _____

Venereal Disease _____Other _____

Surgeries (type and date): _____

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

Significant Dental Work (type and date): _____

Birth History (prolonged labor, forceps delivery, etc.): _____

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

Family Medical History (check): Diabetes _____ Allergies _____ Seizures _____ Heart Disease _____
High Blood Pressure _____ Stroke _____ Asthma _____ Cancer _____
Other _____

Are you currently taking any steroids? _____Yes _____ No
Medicines taken within the last two months (vitamins, drugs, herbs, etc.): _____
_____

Do you have a regular exercise program? Yes _____ No _____ Please describe: _____
_____

Have you ever been on a restricted diet? Yes _____ No _____ what kind? _____
_____

PLEASE DESRIBE YOUR AVERAGE DAILY DIET:
Morning: _____
Afternoon: _____
Evening: _____
How many packs of cigarettes do you smoke per day? _____
How much coffee, tea, or cola do you drink per week? _____
How much alcohol do you drink per week? _____
Please describe any use of drugs for non-medical purposes: _____

Additional Comments: _____
_____
_____
_____

PLEASE CHECK ANY YOU HAVE HAD IN THE LAST THREE MONTHS

NEUROPSYCHOLOGICAL

___ Seizures
___ Areas of numbness
___ Weakness
___ Sleep disorders
___ Concussion
___ Bad temper
___ Loss of control/violence
___ Vertigo
___ Lack of coordination

___ Depression
___ Easily susceptible to stress
___ Loss of balance
___ Poor memory
___ Anxiety
___ Substance abuse
Other neurological or psychological problems
_____
_____

Have you ever been treated for emotional problems? _____
_____
_____

Have you ever considered or attempted suicide?

_____ Yes _____No

GENERAL

___ Chills
___ Fevers
___ Sweat Easily
___ Night Sweats
___ Localized Weakness
___ Bleed or bruise easily
___ Peculiar tastes or smells
___ Strong Thirst (hot or cold)
___ Thirst, no desire to drink
___ Fatigue
___ Sudden energy drop
Time of day? _____
___ Edema
Where _____
___ Poor sleeping
___ Tremors
___ Poor Balance
___ Cravings
___ Change in appetite
___ Weight Gain
___ Weight Loss

SKIN & HAIR

___ Rashes
___ Itching
___ Change in hair or skin
___ Eczema
___ Oozing on skin lesion
___ Hives
___ Pimples
___ Loss of hair
___ Dandruff
___ Other hair or skin problems
_____

HEAD, EYES, EARS NOSE & THROAT

___ Dizziness
___ Migraines
___ Headaches
When: _____
Where: _____
___ Facial pain
___ Glasses
___ Poor vision
___ Night blindness
___ Blurry vision
___ Color Blindness
___ Spots in front of eyes
___ Eye pain
___ Eye strain
___ Cataracts
___ Eye dryness
___ Excessive tearing
___ Discharge from eyes
___ Poor hearing
___ Ringing in ears
___ Earaches
___ Discharge from ear
___ Nose bleeds
___ Sinus congestion
___ Nasal drainage
___ Grinding teeth
___ Teeth problems
___ Jaw clicks
___ Concussions
___ Recurrent sore throats
___ Hoarseness
___ Sores on lips or tongue
Other head or neck problems:
_____

CARDIOVASCULAR

___ High blood pressure
___ Low blood pressure
___ Chest discomfort/pain
___ Heart palpitations
___ Cold hands or feet
___ Swelling of hands
___ Swelling of feet
___ Blood clots
___ Fainting
___ Difficulty in breathing
Other heart or blood vessel problems:
_____

RESPIRATORY

___ Cough
___ Asthma/Wheezing
___ Pain with a deep breath
___ Difficulty in breathing when lying down
___ Production of phlegm
What color: _____
___ Coughing up blood
___ Pneumonia
___ Bronchitis
Other lung problems: _____

GASTROINTESTIONAL

___ Bad breath
___ Nausea
___ Vomiting
___ Heartburn
___ Belching
___ Indigestion
___ Diarrhea
___ Constipation
___ Chronic laxative use
___ Blood in stools
___ Black stools
___ Abdominal pain or cramps
___ Gas
___ Rectal pain
___ Hemorrhoids
Other stomach or intestinal problems:
_____

GENITO-URINARY

___ Pain on urination
___ Urgency to urinate
___ Frequent urination
___ Blood in urine
___ Decrease in flow
___ Unable to hold urine
___ Dribbling
___ Kidney stones
___ Impotency
___ Change in sexual drive
___ Sores on genitals
Other genital or urinary system problems: _____
Do you wake to urinate? ___ Yes ___ No
How often? _____
Any particular color to your urine? _____

PREGNANCY & GYNECOLOGY

___ Number of pregnancies
___ Number of births
___ Premature births
___ Miscarriages
___ Abortions
___ Age at first menses
___ Period between menses
___ Duration
___ First date of last menses
___ Unusual character (heavy/light)
___ Painful periods
___ Irregular periods
___ Changes in body/psyche prior to menses
___ Clots
___ Menopause: Age _____ years
___ Vaginal discharge
___ Post-coital bleeding
___ Vaginal sores
___ Last Pap
___ Breast Lumps
___ Nipple discharge
Do you practice birth control? __Yes __ No
What type & how long? _____

MUSCULOSKELETAL

___ Neck pain
___ Shoulder pain
___ Back pain
___ Elbow pain
___ Hand/wrist pains
___ Hip pain
___ Knee pain
___ Foot/ankle pains
___ Muscle pains
___ Muscle weakness
Other: _____