

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 In HEIGHT: _____ WEIGHT: _____

EMPLOYER NAME: _____ OCCUPATION: _____

FAMILY PHYSICIAN: _____ REFERRED BY: _____

IN EMERGENCY, NOTIFY: _____ PHONE: _____

HAVE YOU BEEN TREATED BY ACUPUNCTURE OR ORIENTAL MEDICINE BEFORE? 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 DESCRIBE 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: _____

GASTROINTESTINAL

- 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: _____