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.

I. General Patient Information

Date: ____/____/____

Name: _____

Address: _____

City, State, Postal Code: _____

Home Phone: _(_____)_____ Work Phone: _(_____)_____Cell:_(_____)_____

Email: _____

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

Guardian (if under 18): _____

Gender: θM θF Height: ____'____" Weight: _____lbs.

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?_____

_____

II. Patient Medical History

How was your childhood health?_____

Hospital Visits/Stays:_____

Surgeries:_____

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

θPhysical	θCholesterol	θProstate	θBlood (which?)
θHIV/STD	θPap smear	θMammography	θOther:_____

Test Results and Date:_____

Circle any you have had in the past

θDiabetes	θAllergies	θGlaucoma	θRheumatic Fever
θHeart Disease	θCVA (stroke)	θVein condition	θThyroid disorder
θAsthma	θPneumonia	θTuberculosis	θEmphysema
θJaundice	θGonorrhea	θMumps	θBleeding tendency
θSyphilis	θMeasles	θChicken pox	θNervous disorder
θMeningitis	θHIV	θPolio	θMononucleosis
θEpilepsy	θHigh fever	θHepatitis	θMultiple Sclerosis
θParalysis	θCancer	θMigraines	θHigh blood pressure
θother lung illnesses	θother liver illnesses	θother heart illnesses	θother kidney illnesses

θother:_____

III. **Patient Profile**

Please clearly mark any areas of pain and any scars (please indicate which of the areas are scars):

Is the pain:

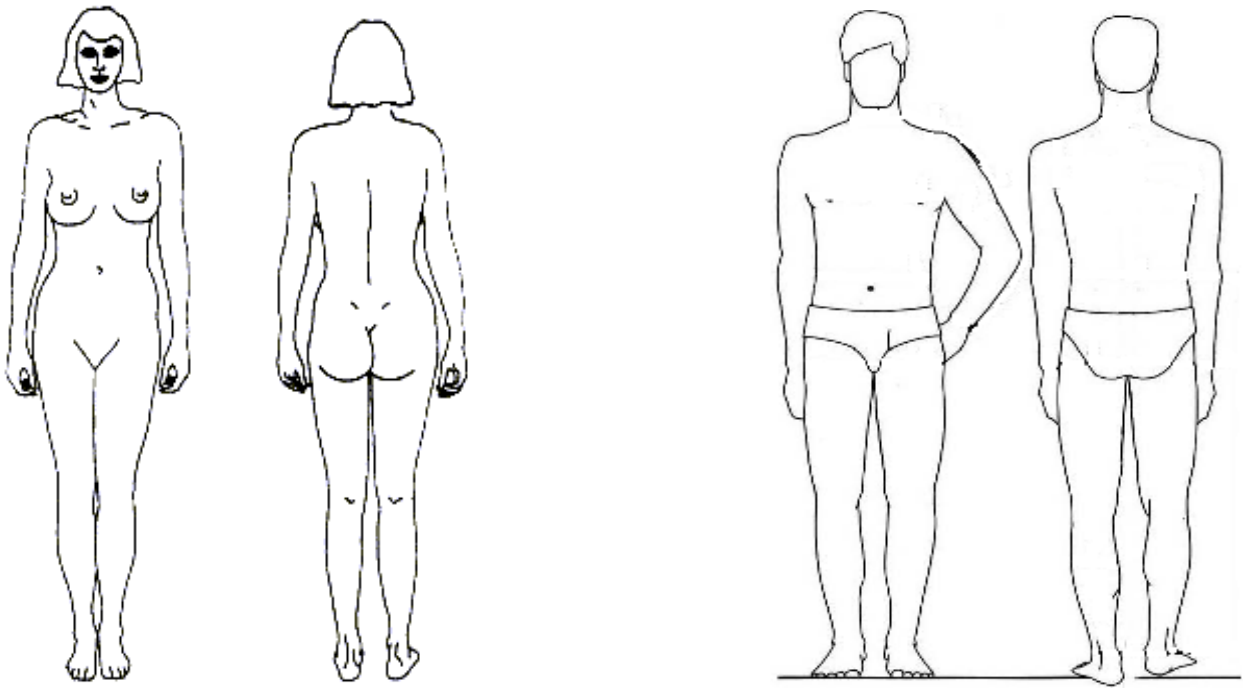
θSharp	θBurning	θAching
θCramping	θDull	θMoving
θFixed	Other:_____	

Do the following lessen the pain?

θPressure	θCold	θHeat
θ Exercise	θOther:_____	

Do the following worsen the pain?

θPressure	θCold	θHeat
θOther:_____		



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):
θCold hands
θCold fingers
θCold feet
θCold toes
θSweaty hands
θSweaty feet
θHot body temperature (sensation)
θCold body temperature (sensation)
θAfternoon flushes
θNight sweats
θHeat in the hands, feet, and chest
θHot flashes any time of the day
θThirsty
θPerspire easily
θLack of perspiration
θTake water to bed

Overall energy (Lung, Kidney function):
θShortness of breath
θDifficulty keeping eyes open in the daytime
θGeneral weakness
θEasily catch colds
θLow energy
θFeel worse after exercise

Overall blood (Liver, Spleen, Heart function):
θDizziness
θSee floating black spots

Heart function:
θPalpitations
θAnxiety
θSores on the tip of the tongue
θRestlessness
θMental confusion
θChest pain traveling to shoulder
θFrequent dreams
θWake unrefreshed
θDrink coffee (# of cups per week: _____)

Lung function:
θNasal Discharge (Color: _____)
θCough
θNose Bleeds
θSinus Congestion
θDry mouth
θDry throat
θDry Nose
θDry Skin
θAllergies (To what? _____)
θAlternating fever and chills
θSneezing
θHeadache (Location: _____)
θOverall achy feeling in the body
θStiff neck
θStiff shoulders
θSore throat
θDifficulty breathing
θSmoke cigarettes (# of cigarettes per day: _____)
θSadness
θMelancholy

Spleen function:
θLow appetite
θAbrupt weight gain
θAbrupt weight loss
θAbdominal bloating
θAbdominal gas
θGurgling noise in the stomach
θFatigue after eating
θProlapsed organs (previously diagnosed, which organ? _____)
θEasily bruised
θHemorrhoids
θPensive
θOver-thinking
θWorry

Spleen, Stomach, Large Intestine, Small Intestine function:
θLoose
θConstipated
θIncomplete
θDiarrhea
θBlood in stools
θMucous in stools
θUndigested food in stools

Dampness trapped in the body:
θGeneral sensation of heaviness in the body
θMental heaviness
θMental sluggishness
θMental fogginess
θSwollen hands
θSwollen feet
θSwollen joints
θChest congestion
θNausea
θSnoring

Stomach function:
θBurning sensation after eating
θLarge appetite
θBad breath
θMouth (canker) sores
θBleeding, swollen or painful gums
θHeartburn
θAcid regurgitation
θUlcer (diagnosed)
θBelching
θHiccoughs
θStomach pain
θVomiting

Liver, Gall Bladder function:
θAlternating diarrhea and constipation
θChest pain
θTight sensation in the chest
θBitter taste in the mouth
θAnger easily
θFrustration
θDepression
θIrritability
θFrequently unable to adapt to stress (What causes the stress? _____)
θSkin rashes
θHeadache at the top of the head
θTingling sensation
θNumbness
θMuscle spasms
θMuscle twitching
θMuscle cramping
θSeizures
θConvulsions
θLump in the throat
θNeck tension
θLimited Range-of-Motion, Neck
θShoulder tension
θLimited Range-of-Motion, Shoulder
θDrink alcohol
θRecreational drugs (Which? _____, How much per week? _____)
θHigh-pitched ringing in the ears
θGall stones (history or current)
θSexually transmitted disease (Which? _____)

Eyes (Liver function):
θItchy
θBloodshot
θHot
θDry
θWatery
θGritty
θBlurry vision
θDecreased night vision
θNear-sighted
θFar-sighted

Kidney, Urinary Bladder function:
θFrequent cavities
θEasily broken bones
θSore knees
θWeak knees
θCold sensation in the knees
θLow back pain
θMemory problems

θExcessive hair loss
θLow-pitched ringing in the ears
θKidney stones
θBladder infections
θWake during the night twice or more to urinate
θLack of bladder control
θFear
θEasily startled

Urination:
θNormal color
θDark yellow
θClear
θReddish
θCloudy
θScanty
θProfuse
θStrong odor
θBurning
θPainful
θDischarge
θDifficult
θPainful
θUrgent
θFrequent

Libido:
θNormal
θHigh
θLow

IV. List ALL the medications you are currently taking. Please include vitamins and other supplements.

V. *Women only*:

Regular menstrual cycle? θY θN
Number of children:_____
Age of first menstruation:_____
Average number of days of flow:_____
θVaginal discharge

Pregnant? θY θN
Number of pregnancies:_____
Age of menopause (if applicable):_____
Average number of days of entire cycle:_____
θBleeding between periods

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

θnausea θvomiting θwater retention θbreast swelling
θfood cravings θheadaches θmigraines θbreast tenderness
θdepression θirritability θanxiety θother emotions:_____
θdull pain, where?_____ θsharp 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							

Men only:

θSwollen testes θTesticular pain θImpotence θPremature ejaculation
θFeeling of coldness or numbness in external genitalia θOther_____

All please fill out:

Other Comments:_____

_____

Patient Signature:_____

Acupuncturist Signature:_____