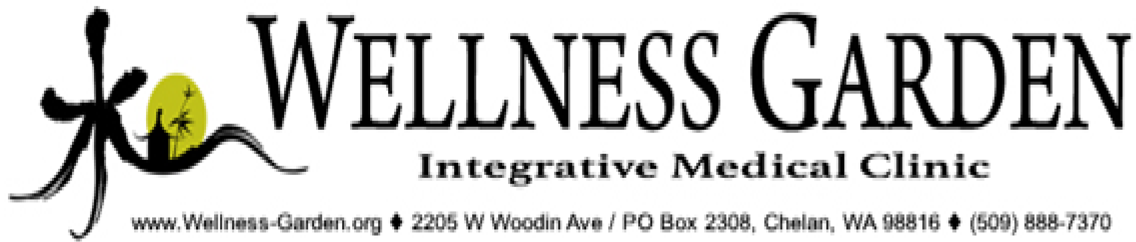


Confidential Health History Questionnaire

Please help us provide you with a complete evaluation by taking the time to fill out this questionnaire carefully. All of your answers will be confidential. If you have questions, please ask. If there is anything you wish to bring to our attention, which is not included on this form, please note it in the comments section or speak to us about it. Thank you.

Name: ________________________________ Home Phone: _________ Cell Phone:_______

Address:_______________________________ City:______________ State:________ Zip: _______________

E-mail address:___________________________ Would you like to be on our mailing list?___________

Date of Birth:______________ Height:______ Weight:____________ Marital Status:_______

Social Security #:________________________ Occupation:_____________________ How Long:_________

Emergency Contact Name:_____________________________ Emergency Contact Phone:________________

Referred By: _________________________________ Family Physician:_____________________________

Have you had acupuncture before:___________ If so, where and when:_______________________________

How would you like to receive your appointment reminders? By Email___ By Phone___ Both___

What is the main problem(s) you would like help with today? (*list in order of importance)*

1. ____
2. ____
3. ____

How long ago did this problem begin? (*please be specific)*

1.________________________ 2.________________________ 3.________________________

What is the cause of this problem: ____
____

What makes it better: (*hot, cold, massage, etc.*) ____
____

What makes it worse: (*activity, weather, AM, PM*) ____
____

What kinds of treatments have you tried:____
____

What treatments have been helpful:____
____

Is your current condition getting: ______better ________ worse _______ comes & goes ________ same

Please note the degree of severity of your problem today:

|______________________________________|______________________________________|

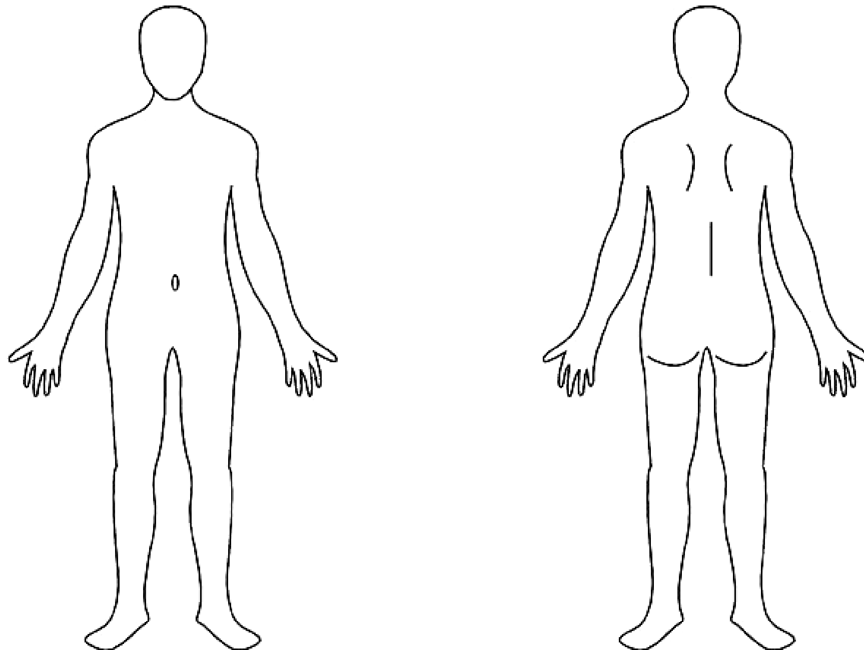
Low/No Problem *High/Worst Imaginable*

Please note the greatest degree of severity of your problem in the past week:

|______________________________________|______________________________________|

Low/No Problem *High/Worst Imaginable*

Please indicate any areas of pain on the diagrams below:



Past Medical History

Please describe any that apply (*please include dates*):

- ☐ Heart disease ______
- ☐ Cancer ______
- ☐ Hypertension ______
- ☐ Thyroid disorder ______
- ☐ Hepatitis ______
- ☐ Diabetes ______
- ☐ Rheumatic Fever ______
- ☐ Asthma/Allergies ______
- ☐ HIV/AIDS ______
- ☐ STDs ______
- ☐ Hereditary disorders ______
- ☐ Seizures ______
- ☐ Stroke ______
- ☐ Neurological disorders ______
- ☐ Other (please specify) ______

Surgeries: *(types & dates)*______

______

Significant Trauma Incidents (auto accidents, falls hitting head, broken bones, etc), (*please include dates)*: ______

______

Allergies and/or Asthma: *to what/how long*______

______

Do you have a regular exercise program? Is so, please describe:______

______

Please describe your average daily diet: Morning:______

Afternoon:______ Evening:______

How many cigarettes do you smoke a day?______ How much nicotine do you chew per week?______

How much alcohol do you drink per week?______ How much coffee/tea/soda do you drink a day?______

Please describe any use of drugs for non-medical purpose:______

Please check any symptoms you have had in the last three months

General

- ☐ Chills
- ☐ Fevers
- ☐ Sweat easily
- ☐ Night sweats
- ☐ Localized weakness
- ☐ Bleed or bruise easily
- ☐ Peculiar tastes or smells
- ☐ Strong thirst (cold / hot)
- ☐ Thirst, no desire to drink
- ☐ Fatigue
- ☐ Sudden energy drop

*Time of day:*__________

- ☐ Edema

*Where:*______________

- ☐ Poor sleeping
- ☐ Tremors
- ☐ Poor balance
- ☐ Cravings
- ☐ Change in appetite
- ☐ Poor appetite
- ☐ Weight change

Gain / Loss ___________

Skin and Hair

- ☐ Rashes
- ☐ Itching
- ☐ Change in hair or skin
- ☐ Ulcerations
- ☐ Eczema
- ☐ Oozing skin lesion
- ☐ Hives
- ☐ Pimples
- ☐ Recent moles
- ☐ Loss of hair
- ☐ Dandruff

Other hair or skin problems

Head, Eyes, Ears Nose, and Throat

- ☐ Dizziness
- ☐ Migraines
- ☐ Headaches

*When:*_____________

Where: _____________

- ☐ Facial pain
- ☐ Glasses
- ☐ Poor vision
- ☐ Night blindness
- ☐ Blurry vision
- ☐ Teeth problems
- ☐ Jaw clicks
- ☐ Concussions
- ☐ Recurrent sore throats
- ☐ Hoarseness
- ☐ Sores on lips/tongue

Other head / 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/blood vessel problems:

Respiratory

- ☐ Cough
- ☐ Asthma/wheezing
- ☐ Difficulty in breathing when lying down
- ☐ Phlegm *Color?*________
- ☐ Coughing blood
- ☐ Pneumonia
- ☐ Bronchitis

*Other lung problems:*______

Gastrointestinal

- ☐ Bad breath
- ☐ Nausea
- ☐ Vomiting
- ☐ Heartburn
- ☐ Belching
- ☐ Indigestion
- ☐ Diarrhea
- ☐ Constipation
- ☐ Hemorrhoids
- ☐ Chronic laxative use
- ☐ Blood in stools
- ☐ Black stools
- ☐ Abdominal pain/cramps
- ☐ Gas
- ☐ Rectal pain

Other stomach or intestinal

*Other genital or urinary system problems?*________

____

Pregnancy and Gynecology

of pregnancies:

# of births:

premature births:

of miscarriages:

# of abortions:

Age at first menses:

Length of full cycle:

Length of menses:

Last menses start date:

- ☐ Heavy periods
- ☐ Light periods
- ☐ Painful periods
- ☐ Irregular periods
- ☐ Changes in body/psyche prior to menstruation
- ☐ Clots
- ☐ Vaginal discharge:
- ☐ Menopause:

Age:

Year:

- ☐ Postcoital bleeding
- ☐ Vaginal sores
- ☐ Breast lumps
- ☐ Nipple discharge

Do you practice birth control?

☐ Yes ☐ No

What type and for how long?

____

Musculoskeletal

- ☐ Neck pain
- ☐ Shoulder pain
- ☐ Back pain
- ☐ Elbow pain
- ☐ Hand/wrist pain
- ☐ Hip pain
- ☐ Knee pain
- ☐ Foot/ankle pain
- ☐ Muscle pain
- ☐ Muscle weakness

Other pain? ____________

____

Neuropsychological

- ☐ Seizures

- ☐ Color blindness
- ☐ Blind field
- ☐ 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

*problems:*_______________

Genito-Urinary

- ☐ Pain on urination
- ☐ Urgency to urinate
- ☐ Frequent urination
- ☐ Blood in urine
- ☐ Decrease in flow
- ☐ Dribbling
- ☐ Kidney stones
- ☐ Impotency
- ☐ Change of sexual drive
- ☐ Sores on genitals

Do you wake to urinate?

☐ Yes ☐ No

How often? _____________

What color is your urine?

____

- ☐ Areas of numbness
- ☐ Weakness
- ☐ Sleep disorder
- ☐ Concussion
- ☐ Violence potential
- ☐ Vertigo
- ☐ Lack of coordination
- ☐ Bad temper
- ☐ Depression
- ☐ Easily stressed
- ☐ Loss of balance
- ☐ Poor memory
- ☐ Anxiety
- ☐ Substance abuse

Have you ever been treated for emotional problems?

☐ Yes ☐ No

Comments: *Please tell us about any other problems you would like to discuss:*

____

____

____

____

Supplement and Medication List

Date Started	Date Discontinued	Supplement/Dosage	Doctor
Date Started	**Date Discontinued**	**Prescription Medication/Dosage**	**Doctor**

Please add additional paper if necessary for supplements and medications.