

## *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

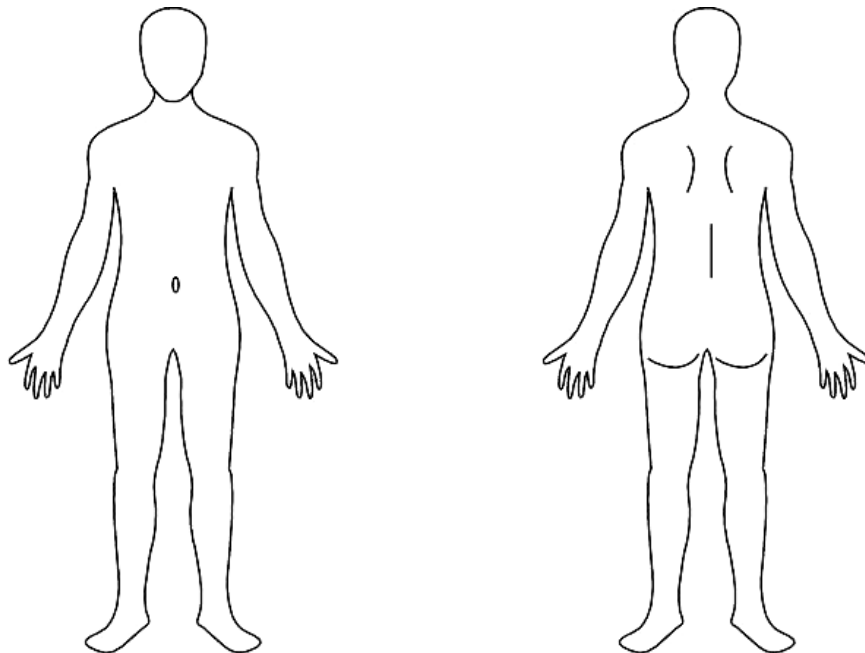
Please note the degree of severity of your problem today:

_____	_____
<i>Low/No Problem</i>	<i>High/Worst Imaginable</i>

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

_____	_____
<i>Low/No Problem</i>	<i>High/Worst Imaginable</i>

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**

Teeth problems

*Other genital or urinary*

- 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: \_\_\_\_\_

Where: \_\_\_\_\_

- Edema
- 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
- Color blindness
- Blind field
- Spots in front of eyes
- Eye pain

- 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 problems: \_\_\_\_\_

### Genito-Urinary

- Pain on urination
- Urgency to urinate

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
- Areas of numbness
- Weakness
- Sleep disorder
- Concussion

- 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

- 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?*
- \_\_\_\_\_*

- 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:*

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### **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.*