HEALTH HISTORY QUESTIONNAIRE

Welcome to our clinic! 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 held absolutely confidential. If you have questions, please ask us. If there is anything you wish to bring to our attention which is not asked on this form, please note it in the **Comments** section. Thank you!

NAME:_____
ADDRESS:_____
CITY _____ STATE_____ ZIP _____
Home Phone: _____Work Phone: _____E-Mail:_____
Date of Birth:_____ Age: _____ Height: _____Weight: _____
Place of Birth:_____ Social Security Number: _____
Occupation: _____ Marital Status: _____
In Emergency Notify: _____
Referred by: _____
Family Physician/Phone Number: _____
Employers' Name & Address:_____
Insurance Carrier: _____ Policy #:_____Group#:._____
Have you tried acupuncture or Chinese herbal medicine before? _____

MAIN PROBLEM(S) YOU WOULD LIKE TO ADDRESS

To what extent does this problem affect your daily activities (work, sleep, eating, etc.)?

_____
_____
How long has it been since you first noticed any symptoms? _____
Have you been given a diagnosis for the problem by you family physician? _____
If so, what is it? _____
What kinds of treatment or therapy have you tried? _____

PAST MEDICAL HISTORY (PLEASE INCLUDE DATES):

☐Allergies
☐Cancer
☐Diabetes
☐Hepatitis
☐High Blood Pressure
☐Heart Disease
☐Seizures
☐Rheumatic Fever
☐Surgeries
☐Venereal Disease
☐Thyroid Disease
☐Birth Trauma (prolonged labor, forceps delivery, etc)
☐Other Significant illness (describe)
_____
_____
_____
☐Accidents or Significant Trauma (describe)_____
_____

OTHER RELEVANT MEDICAL HISTORY

_____
_____
_____

FAMILY MEDICAL HISTORY

☐ Allergies	☐ Cancer	☐ Seizures
☐ Diabetes	☐ Heart Disease	☐ Stroke
☐ Asthma	☐ High blood Pressure	☐ Other

OCCUPATION : _____

Occupational stress factors (physical, psychological, chemical): _____

_____

LIFESTYLE: _____

Do you follow a regular exercise program? _____ If so, please describe: _____

_____

Please describe your average daily diet? _____

_____

Please check any of the following habits that apply. How much and how often do you use them:

☐ Cigarette smoking ☐ Coffee, tea or cola ☐ Alcohol beverages

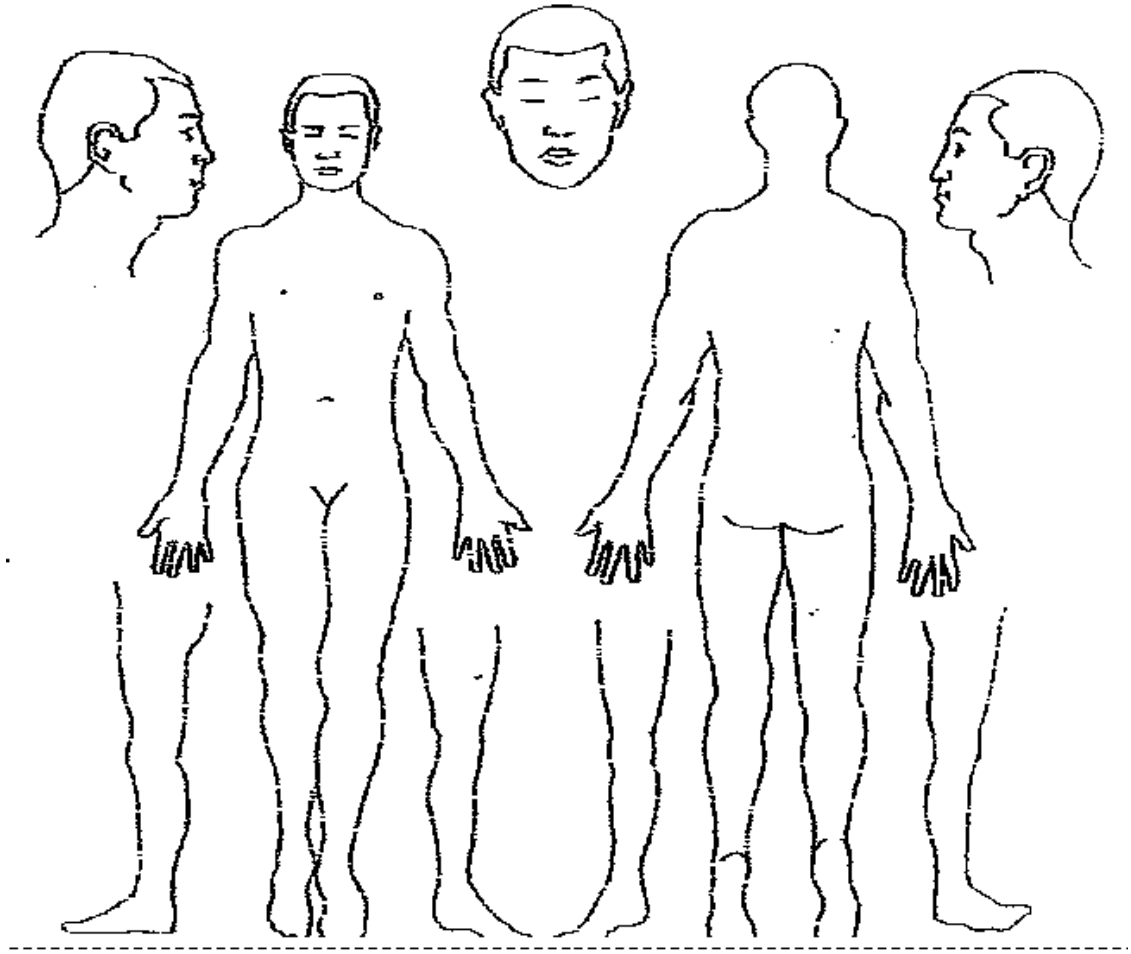
List medications taken within last two months (vitamins, drugs, herbs, etc.): _____

_____

Please describe any drug use for non-medical purposes: _____

_____

Please mark painful or distressed areas on the chart below



PLEASE PUT A CHECK NEXT TO ANY CONDITION YOU'VE EXPERIENCED IN THE LAST THREE MONTHS, CIRCLE THOSE YOU'VE EXPERIENCED IN THE PAST. INDICATE THE LENGTH OF TIME YOU HAVE HAD THIS CONDITION.

GENERAL

- ☐ Poor appetite
- ☐ Insomnia
- ☐ Disturbed sleep
- ☐ Localized weakness
- ☐ Cravings
- ☐ Strong thirst
- ☐ Weight gain
- ☐ Weight loss
- ☐ Changes in appetite
- ☐ Sweating easily
- ☐ Tremors
- ☐ Bleeding or bruising easily
- ☐ Night Sweats
- ☐ Fever
- ☐ Chills
- ☐ Sudden energy drop (time of day)
- ☐ Poor balance

Other unusual or abnormal conditions you have noticed in your general sense of health

_____

_____

SKIN & HAIR

- ☐ Rashes
- ☐ Ulcerations
- ☐ Hives
- ☐ Itching
- ☐ Eczema
- ☐ Pimples
- ☐ Dandruff
- ☐ Hair loss
- ☐ Recent moles
- ☐ Changes in texture of hair or skin

Any other hair or skin problems_____

HEAD, EYES, EARS, NOSE, THROAT

- ☐ Dizziness
- ☐ Concussions
- ☐ Migraines
- ☐ Glasses
- ☐ Spots in front of eyes
- ☐ Eye pain
- ☐ Poor vision
- ☐ Night blindness
- ☐ Color blindness
- ☐ Cataracts
- ☐ Blurry vision
- ☐ Earaches
- ☐ Ringing in ears
- ☐ Poor hearing
- ☐ Eye strain
- ☐ Sinus problems
- ☐ Recurrent sore throats
- ☐ Nose bleeds
- ☐ Grinding teeth
- ☐ Sores on lips or tongue
- ☐ Facial pain
- ☐ Teeth problems
- ☐ Headaches (where? when?)
- ☐ Jaw clicks

Any other head or neck problems _____

CARDIOVASCULAR

- ☐ Dizziness
- ☐ Low blood pressure
- ☐ Chest pain
- ☐ Irregular heartbeat
- ☐ High blood pressure
- ☐ Fainting
- ☐ Cold hands or feet
- ☐ Swelling of hands
- ☐ Swelling of feet
- ☐ Blood clots
- ☐ Difficulty in breathing
- ☐ Phlebitis

Any other heart or blood vessel problems_____

RESPIRATORY

- ☐ Cough
- ☐ Coughing up blood
- ☐ Asthma
- ☐ Bronchitis
- ☐ Pain with deep inhalation
- ☐ Pneumonia
- ☐ Difficulty breathing when lying down
- ☐ Excessive phlegm (color?)

Any other lung problems_____

GASTROINTESTINAL

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

Any other problems with stomach or intestines: _____

GENITOURINARY

☐ Pain while urinating	☐ Urgency to urinate	☐ Decrease in flow
☐ Frequent urination	☐ Unable to hold urine	☐ Impotence
☐ Blood in urine	☐ Kidney stones	☐ Sores on genitals

Do you wake up at night to urinate? _____ If so, how often? _____

Any particular color to your urine? _____

Any other genital or urinary problems? _____

REPRODUCTIVE AND GYNECOLOGIC

☐ Premenstrual changes	☐ Heavy menstrual flow	☐ Premature births
☐ Menstrual clots	☐ Light menstrual flow	☐ Miscarriages
☐ Painful menses	☐ Irregular menses	☐ Abortions
☐ Unusual menses	☐ Other problems	

Age at first menses _____ Age at menopause _____ Number of pregnancies _____

Time between cycles _____ Duration of bleeding _____ First day of last menses _____

Do you practice birth control? _____ If so, what type? _____ For how long? _____

Any other gynecologic problems? _____

MUSCULOSKELETAL

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

Any other joint or bone problems? _____

NEUROPSYCHOLOGICAL

☐ Seizures	☐ Poor memory	☐ Anxiety
☐ Dizziness	☐ Lack of coordination	☐ Bad temper
☐ Loss of balance	☐ Concussion	☐ Easily susceptible to stress
☐ Areas of numbness	☐ Depression	

Have you ever been treated for emotional problems? _____

Have you ever considered or attempted suicide? _____

Any other neurological or psychological problems? _____

COMMENTS

Please list any other problems you would like to discuss:

_____