Health History Questionnaire

Information for your Acupuncturist.

Please complete this document as thoroughly as possible. Some of the questions that follow may seem unrelated to your condition, however, they may play a major role in diagnosis and treatment. All information is strictly confidential.

General Patient Information

Date: _____ / _____ / _____

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Email: _____ Would you like to receive our e-mail newsletter? ☐ YES ☐ NO

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

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Domestic Partnership ☐ Other

Name of Spouse/Partner/Other: _____

Guardian (if under 18): _____

Gender: ☐ MALE ☐ FEMALE Height: _____ Weight: _____

Social Security Number: _____ – _____ – _____ Drivers License Number: _____

Occupation: _____ Employer: _____

Employer Address: _____

City: _____ State: _____ Zip Code: _____

Goal from acupuncture or other services we offer: _____

Is there anything limiting you from care? ☐ NO ☐ YES (explain) _____

Name of primary physician/practitioner: _____

How did you hear about our office? _____

Other physicians/therapists seen for this: _____

Medications you are currently taking: 1) _____ 2) _____ 3) _____

4) _____ 5) _____ 6) _____ 7) _____

Prescribed by: _____

For treatment of: _____

_____

Results: _____

Supplements/Vitamins/Herbs: _____

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Major complaints, on order of significance to you:

	SEVERE	MODERATE	SLIGHT	NORMAL
_____	☐	☐	☐	☐
_____	☐	☐	☐	☐
_____	☐	☐	☐	☐
_____	☐	☐	☐	☐
_____	☐	☐	☐	☐
_____	☐	☐	☐	☐

How do these conditions impair your daily activities? _____

_____

_____

Patient Medical History

How was your childhood health? _____

Hospital Visits/Stays: _____

_____

Recent tests *(indicate results and date below)*

☐ Physical ☐ Cholesterol ☐ Prostate ☐ Blood (which) _____

☐ HIV/STD ☐ Pap smear ☐ Mammography ☐ Hormone (saliva)

☐ Thermography ☐ Other

Test Results and date: _____

_____

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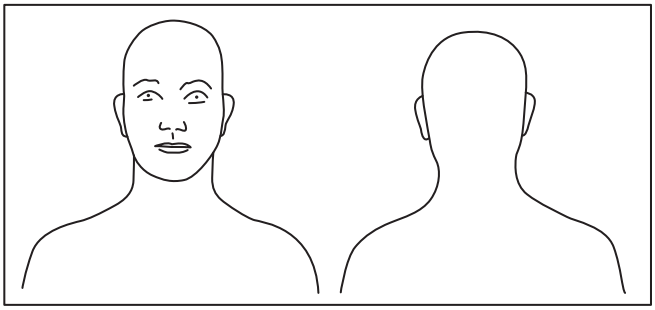
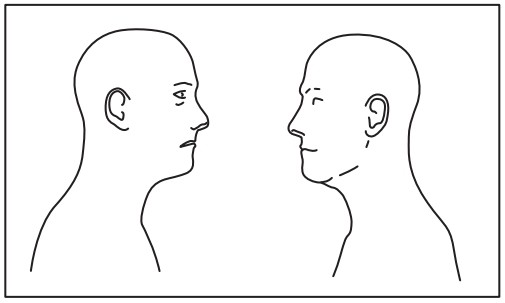
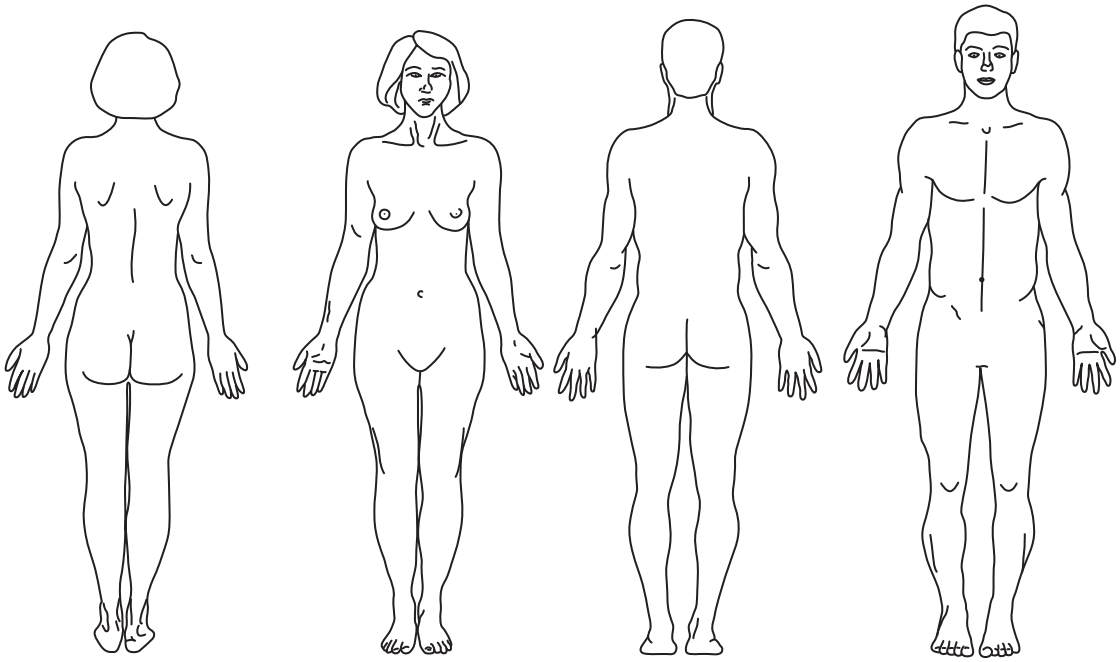
Body Injury Sheet

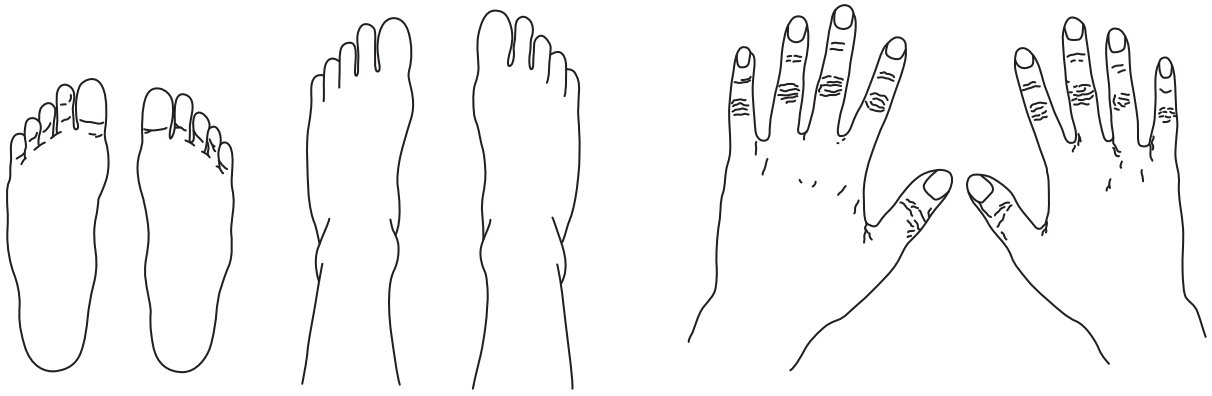
Please draw or shade any AREAS of old injuries you sustained (as best you can remember).
Examples: scars, whiplash from auto accident injuring neck or chin hitting dashboard, head injury, blows to the body from falls or hits (ex. falling on your tail bone, hit in the nose or on the head), surgeries, broken bones (ex. broke rib, toe, arm), muscle, tendon or ligament tears, organs removed, etc.

Now circle the AREA(S) of the body you had any past infections.
Examples: sore throat, tonsils swollen, ear infections, lung infection, bronchial infections, bladder infections, sinus infection, appendix, etc.









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NEW PATIENT HEALTH HISTORY QUESTIONNAIRE

Dear New Patient:

a. Please **read** and **fill in** all of the information that pertains to you.
b. On pages 2 through 11, under each category, **check all** symptoms that you experience either *acutely* or *chronically.*
c. **Add** and **total** all of the boxes you checked.
d. **Date** today's day.

	TEST	***DATE***	***TEST RESULTS***
	Physical	_____	_____
	Cholesterol	_____	_____
	Prostate	_____	_____
	Mammography	_____	_____
	Pap Smear	_____	_____
	Blood (which test?)	_____	_____
	HIV/STD	_____	_____
	Other	_____	_____

Please indicate if you have (or have been tested for) any of the following:							
	Diabetes		Allergies		Rheumatic Fever		Vein Condition
	Heart Disease		CVA (stroke)		Thyroid Disorder		Tuberculosis
	Asthma		Pneumonia		Emphysema		Chicken Pox
	High Blood Pressure		Gonorrhea		Bleeding Tendency		Polio
	Syphilis		Measles		Nervous Disorder		Migraines
	Meningitis		HIV		Mononucleosis		Other Liver Illnesses
	Epilepsy		High Fever		Multiple Sclerosis		Other Heart Illnesses
	Paralysis		Cancer		Jaundice		Other Kidney Illnesses
	Glaucoma		Mumps		Hepatitis		Other Lung Illnesses

IMMUNIZATIONS?

_____
_____
_____
_____
_____

SURGERIES?

_____
_____
_____
_____
_____

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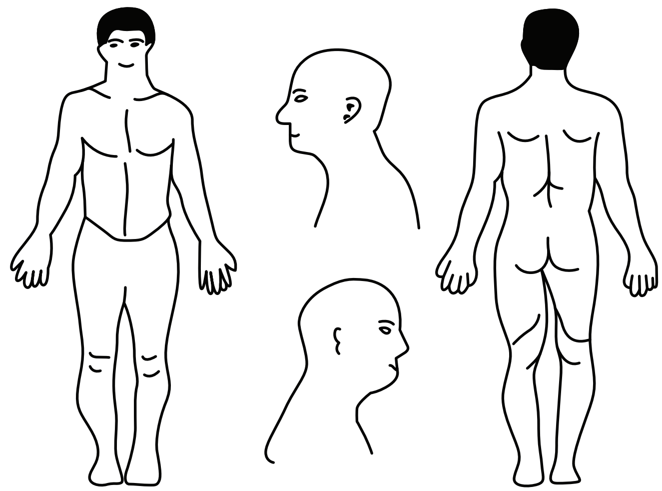
NEW PATIENT HEALTH HISTORY QUESTIONNAIRE

1. Pain:

	What makes the pain better?
☐	Soft Pressure
☐	Hard Pressure
☐	Cold
☐	Heat
☐	Exercise
☐	Rest
☐	Other

	What makes the pain worse?
☐	Soft Pressure
☐	Hard Pressure
☐	Cold
☐	Heat
☐	Exercise
☐	Other

On the figures below, please mark clearly any areas of pain and indicate any scars.



2. Describe your pain:

		#1	#2	#3	#4	#5	#6	#7	#8	#9	#10	#11	#12
☐	Sharp	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
☐	Fixed	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
☐	Burning	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
☐	Moving	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
☐	Cramping	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
☐	Aching	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
☐	Dull	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
☐	Other:______________________	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
☐	***Total Boxes Checked***	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
	Date:____________ RE Date:	/	/	/	/	/	/	/	/	/	/	/	/

FOR LONG TERM-CARE PATIENTS ONLY: On the day of your **RE-EXAM,** only check the boxes that **NO LONGER** pertain to you, or if you **HAVE NOT** experienced the symptoms for two weeks. **Add** up your boxes and **date**.

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boxes that **NO LONGER** pertain to you, or if you **HAVE NOT** experienced the symptoms for

NEW PATIENT HEALTH HISTORY QUESTIONNAIRE

3. *Kidney Function:*
(Overall Temperature)
Hormones

On the day of your **RE-EXAM,** only check the boxes that **NO LONGER** pertain to you, or if you **HAVE NOT** experienced the symptoms for two weeks. **Add** up your boxes and **date.**

	#1	#2	#3	#4	#5	#6	#7	#8	#9	#10	#11	#12
☐ Cold Hands												
☐ Cold Fingers												
☐ Cold Toes												
☐ Cold Feet												
☐ Sweaty Hands												
☐ Sweaty Feet												
☐ Hot Body Temperature Sensation												
☐ Cold Body Temperature Sensation												
☐ Afternoon Flushes												
☐ Night Sweats												
☐ Heat in the hands, feet & chest												
☐ Hot flashes any time of the day												
☐ Thirsty												
☐ Perspire easily												
☐ Lack of perspiration												
☐ Do you take water to bed												
☐ ***Total Boxes Checked***												
	⁄	⁄	⁄	⁄	⁄	⁄	⁄	⁄	⁄	⁄	⁄	⁄

Date:_____ RE Date:

4. *Lung, Kidney Function:*
(Overall Energy)

On the day of your **RE-EXAM,** only check the boxes that **NO LONGER** pertain to you, or if you **HAVE NOT** experienced the symptoms for two weeks. **Add** up your boxes and **date.**

	#1	#2	#3	#4	#5	#6	#7	#8	#9	#10	#11	#12
☐ Shortness of Breath												
☐ Difficulty keeping eyes open (daytime)												
☐ General Weakness												
☐ Easily catch colds												
☐ Low Energy												
☐ Feel worse after exercise												
☐ Chronic (daily) fatigue & malaise												
☐ ***Total Boxes Checked***												
	⁄	⁄	⁄	⁄	⁄	⁄	⁄	⁄	⁄	⁄	⁄	⁄

Date:_____ RE Date:

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NEW PATIENT HEALTH HISTORY QUESTIONNAIRE

5. Liver, Spleen, Heart Function:

FOR LONG TERM-CARE PATIENTS ONLY: On the day of your **RE-EXAM,** only check the Boxes that **NO LONGER** pertain to you, or if you **HAVE NOT** experienced the symptoms for Two weeks. **Add** up your boxes and **date.**

	#1	#2	#3	#4	#5	#6	#7	#8	#9	#10	#11	#12
☐ Dizziness												
☐ See floating black spots												
☐ ***Total Boxes Checked***												
Date:_____ RE Date:												

6. Heart Function: Emotional

FOR LONG TERM-CARE PATIENTS ONLY: On the day of your **RE-EXAM,** only check the Boxes that **NO LONGER** pertain to you, or if you **HAVE NOT** experienced the symptoms for Two weeks. **Add** up your boxes and **date.**

	#1	#2	#3	#4	#5	#6	#7	#8	#9	#10	#11	#12
☐ Anxiety												
☐ Sores on tip of tongue												
☐ Restlessness												
☐ Mental confusion												
☐ Chest pain traveling to shoulder												
☐ Frequent dreams												
☐ Wake unrefreshed												
☐ Coffee? How much per week?_____												
☐ ***Total Boxes Checked***												
Date:_____ RE Date:												

7. Spleen Function: Digestive

FOR LONG TERM-CARE PATIENTS ONLY: On the day of your **RE-EXAM,** only check the Boxes that **NO LONGER** pertain to you, or if you **HAVE NOT** experienced the symptoms for Two weeks. **Add** up your boxes and **date.**

	#1	#2	#3	#4	#5	#6	#7	#8	#9	#10	#11	#12
☐ Low Appetite												
☐ Abrupt Weight Gain												
☐ Abrupt Weight Loss												
☐ Abdominal Bloating												
☐ Abdominal Gas												

Spleen function continued next page...

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NEW PATIENT HEALTH HISTORY QUESTIONNAIRE

7. Spleen Function, continued...

- ☐ Gurgling noise in Stomach
- ☐ Fatigue after eating
- ☐ Prolapsed Organs? Which?_____
- ☐ Bruise easily?
- ☐ Over-Thinking
- ☐ Worry

☐ ***Total Boxes Checked***

Date:_____ RE Date:

#1	#2	#3	#4	#5	#6	#7	#8	#9	#10	#11	#12
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
/	/	/	/	/	/	/	/	/	/	/	/

8. Lung Function Respiratory & Skin

On the day of your **RE-EXAM,** only check the boxes that **NO LONGER** pertain to you, or if you **HAVE NOT** experienced the symptoms for two weeks. **Add** up your boxes and **date.**

- ☐ Nasal Discharge (color_____)
- ☐ Cough
- ☐ Nose Bleeds
- ☐ Sinus Congestion
- ☐ Dry Mouth
- ☐ Dry Throat
- ☐ Dry Nose
- ☐ Dry Skin
- ☐ Allergies (what?_____)
- ☐ Alternating Chills/Fever
- ☐ Sneezing
- ☐ Headache (location_____)
- ☐ Overall achy feeling in body
- ☐ Stiff Neck
- ☐ Stiff Shoulders
- ☐ Sore Throat
- ☐ Difficulty breathing
- ☐ Smoke cigarettes (# per day_____)
- ☐ Sadness
- ☐ Melancholy

☐ ***Total Boxes Checked***

Date:_____ RE Date:

#1	#2	#3	#4	#5	#6	#7	#8	#9	#10	#11	#12
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
/	/	/	/	/	/	/	/	/	/	/	/

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NEW PATIENT HEALTH HISTORY QUESTIONNAIRE

7. *Spleen, Stomach, Small/Large Intestine Function*

On the day of your **RE-EXAM,** only check the boxes that **NO LONGER** pertain to you, or if you **HAVE NOT** experienced the symptoms for two weeks. **Add** up your boxes and **date.**

	#1	#2	#3	#4	#5	#6	#7	#8	#9	#10	#11	#12
☐ Loose Stools												
☐ Constipated												
☐ Incomplete Stools												
☐ Diarrhea												
☐ Blood in Stools												
☐ Mucous in Stools												
☐ Undigested food in the Stools												
☐ ***Total Boxes Checked***												
Date:_____ RE Date:												

10. *Stomach Function: Digestive*

On the day of your **RE-EXAM,** only check the boxes that **NO LONGER** pertain to you, or if you **HAVE NOT** experienced the symptoms for two weeks. **Add** up your boxes and **date.**

	#1	#2	#3	#4	#5	#6	#7	#8	#9	#10	#11	#12
☐ Burning sensation after eating												
☐ Large appetite												
☐ Bad Breath												
☐ Canker Sores (mouth)												
☐ Bleeding, swollen or painful gums												
☐ Heartburn												
☐ Acid Regurgitation												
☐ Ulcer (diagnosed?)												
☐ Belching												
☐ Hiccups												
☐ Stomach Pain												
☐ Vomiting												
☐ ***Total Boxes Checked***												
Date:_____ RE Date:												

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NEW PATIENT HEALTH HISTORY QUESTIONNAIRE

11. *Dampness trapped in the Body:*

On the day of your **RE-EXAM,** only check the boxes that **NO LONGER** pertain to you, or if you **HAVE NOT** experienced the symptoms for two weeks. **Add** up your boxes and **date.**

	#1	#2	#3	#4	#5	#6	#7	#8	#9	#10	#11	#12
☐ Bodily sensation of heaviness												
☐ Mental heaviness												
☐ Mental sluggishness												
☐ Mental fogginess												
☐ Swollen hands												
☐ Swollen feet												
☐ Swollen joints												
☐ Chest congestion												
☐ Nausea												
☐ Snoring												
☐ ***Total Boxes Checked***												
Date:_____ RE Date:												

12. *Liver Function (eyes):*

On the day of your **RE-EXAM,** only check the boxes that **NO LONGER** pertain to you, or if you **HAVE NOT** experienced the symptoms for two weeks. **Add** up your boxes and **date.**

	#1	#2	#3	#4	#5	#6	#7	#8	#9	#10	#11	#12
☐ Itchy												
☐ Bloodshot												
☐ Hot												
☐ Dry												
☐ Watery												
☐ Gritty												
☐ Blurry Vision												
☐ Decreased Night Vision												
☐ Near-sighted												
☐ Far-sighted												
☐ ***Total Boxes Checked***												
Date:_____ RE Date:												

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NEW PATIENT HEALTH HISTORY QUESTIONNAIRE

13. *Liver, Gall Bladder Function: Muscles, Tendons, Skin, Stress*

On the day of your **RE-EXAM,** only check the boxes that **NO LONGER** pertain to you, or if you **HAVE NOT** experienced the symptoms for two weeks. **Add** up your boxes and **date.**

	#1	#2	#3	#4	#5	#6	#7	#8	#9	#10	#11	#12
☐ Alternating Diarrhea & Constipation												
☐ Chest Pain												
☐ Tight sensation in the Chest												
☐ Bitter taste in the mouth												
☐ Anger easily												
☐ Depression												
☐ Frustration												
☐ Irritability												
☐ Skin Rashes												
☐ Headache at the top of the Head												
☐ Tingling Sensation												
☐ Numbness												
☐ Muscle twitching												
☐ Muscle cramping												
☐ Muscle Spasms												
☐ Seizures												
☐ Convulsions												
☐ Lump in the throat												
☐ Neck Tension												
☐ Shoulder Tension												
☐ Limited Range-of-Motion (Neck)												
☐ Limited Range-of-Motion (Shoulder)												
☐ How much Alcohol / day?_____												
☐ Recreational drugs (which?_____)												
☐ High-pitched Ringing in Ears												
☐ Gallstones (history or current)												
☐ STD's (which?_____)												
☐ Unable to adapt to Stress												
☐ ***Total Boxes Checked***												
Date:_____ RE Date:												

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NEW PATIENT HEALTH HISTORY QUESTIONNAIRE

14. *Kidney, Urinary Bladder Function: Bones, Pain, Stress*

On the day of your **RE-EXAM,** only check the boxes that **NO LONGER** pertain to you, or if you **HAVE NOT** experienced the symptoms for two weeks. **Add** up your boxes and **date.**

	#1	#2	#3	#4	#5	#6	#7	#8	#9	#10	#11	#12
☐ Frequent cavities, teeth problems												
☐ Easily broken bones												
☐ Sore knees												
☐ Weak knees												
☐ Cold sensation in the knees												
☐ Low Back Pain												
☐ Memory problems												
☐ Excessive hair loss												
☐ Low-pitched ringing in the ears												
☐ Kidney Stones												
☐ Bladder Infections												
☐ Lack of bladder control												
☐ Wake during the night 2 (or more) times to urinate?												
☐ Fear												
☐ Easily startled												
☐ ***Total Boxes Checked***												
Date:_____ RE Date:												

15. *Libido: Sexual Energy*

On the day of your **RE-EXAM,** only check the boxes that **NO LONGER** pertain to you, or if you **HAVE NOT** experienced the symptoms for two weeks. **Add** up your boxes and **date.**

	#1	#2	#3	#4	#5	#6	#7	#8	#9	#10	#11	#12
☐ Normal												
☐ High												
☐ Low												
☐ ***Total Boxes Checked***												
Date:_____ RE Date:												

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