

**Health History Questionnaire**

**Today's Date** \_\_\_\_\_

<b>Patient Name</b> (First, Middle Init., Last.)		<b>DOB</b>	<b>Sex</b>	<b>Height</b>	<b>Weight</b>
<b>Patient Address</b>			<b>Phone</b> (including area code)		
<b>City</b>	<b>State</b>	<b>Zip</b>	<b>Email</b>		
<b>Emergency Contact and Phone</b>		<b>Primary Physician and Phone</b>			
<b>How Did You Hear About Us?</b>		<b>Had Acupuncture Before? If so, where/when?</b>			

What is your main complaint today? \_\_\_\_\_

Do you have a second complaint? \_\_\_\_\_

When did this problem begin? \_\_\_\_\_

What do you think caused it? Is the cause still present? \_\_\_\_\_

What treatments have you tried already? What were the results? \_\_\_\_\_

How severe is your problem right now? (Please mark the scale below)

No problem	Moderate	Worst Imaginable

What's the most severe level you have endured within the last week? (Please mark the scale below)

No problem	Moderate	Worst Imaginable

**Past Medical History** (please indicate with a "Y" for You or "F" for Family. Use both initials when appropriate)

Cancer \_\_\_\_\_ High Blood Pressure \_\_\_\_\_ Rheumatic Fever \_\_\_\_\_ Venereal Disease \_\_\_\_\_  
 Diabetes \_\_\_\_\_ Heart Disease \_\_\_\_\_ Seizures \_\_\_\_\_ Asthma \_\_\_\_\_  
 Hepatitis \_\_\_\_\_ Stroke \_\_\_\_\_ Thyroid Disease \_\_\_\_\_ Pacemaker \_\_\_\_\_  
 Other: \_\_\_\_\_

Allergies (drugs, chemicals, foods, animals): \_\_\_\_\_

Do you exercise regularly? (Y or N) Please describe: \_\_\_\_\_

**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
- 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
- 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
- Chronic laxative use
- Blood in stools
- Black stools
- Abdominal pain/cramps
- Gas
- Rectal pain
- Hemorrhoids

Other stomach or intestinal 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?  
\_\_\_\_\_

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:  
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
- 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

Patient Name: \_\_\_\_\_

Date: \_\_\_\_\_

**Habits** Please indicate below and add comments if you like

	Excessive	Moderate	Minimal	None	
Alcohol:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	.....
Coffee:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	.....
Tea:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	.....
Tobacco:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	.....
Exercise:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	.....
Sleep:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	.....
Appetite:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	.....
Energy Level:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	.....
Medication:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	.....
Vitamins:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	.....
Food Intake:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	.....
Teeth problems:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	.....
Drugs:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	.....
Salt Intake:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	.....
Other:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	.....
Stress Level:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	.....

**Diet** Please give a general description of the food you eat during a "typical" day.

Morning: .....

Afternoon: .....

Evening: .....

Before bed: .....

Between meals: .....

Are you now, or have you ever been, on a restricted diet? Please describe what and when.

\_\_\_\_\_  
\_\_\_\_\_

What medicines have you taken within the last 2 months? (prescriptions, vitamins, over-the-counter drugs, herbs)

\_\_\_\_\_  
\_\_\_\_\_