



Health History Questionnaire

Name: _____ Birthday: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Ph: _____ Work Ph: _____ E-mail: _____

Employer: _____ Occupation: _____

S.S.N. (only nec if using insurance) _____ Height: _____ Weight: _____ Sex: M / F

Marital Status (circle one): Never Married / Married / Separated / Living with Partner / Divorced / Widowed

Family Physician: _____ Referred By: _____

Emergency Contact Name and Number: _____

Have you ever been treated by Acupuncture or Oriental Medicine before? _____

What is your main concern(s) that you would like help with? _____

When did this begin? (Please be specific.) _____

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

Have you been given a diagnosis for this condition? If so, what? _____

What kind of treatments have you tried? What were the results? _____

To what extent does this condition interfere with your daily activities (eg. work, sleep, eating, sex) ? _____

Habits Please indicate below: None, Light, Moderate, or Heavy. Please add comments where significant.

	Excessive	Moderate	Minimal	None	
Alcohol:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Coffee / 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"/>
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"/>
Stress Level:	<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"/>

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

Morning:

Afternoon:

Evening:

Between meals:

Are you now, or have you ever been, on a restricted diet? Please describe the diet and give the start/stop dates:

What allergies do you have? What reactions do you have to these chemicals, foods, drugs, animals, etc?

Family Medical History

High Blood Pressure

Alcoholism

Cancer:

Allergies:

Heart Disease

Seizures

Arteriosclerosis

Asthma

Stroke

Diabetes

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
- 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/whooping
- 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

* Please check any symptoms you have had in the past month