

# Health History Questionnaire

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*Information for your Acupuncturist*

Important: Please complete this document as thoroughly as possible. Some of the questions that follow may seem unrelated to your condition, but they may play a major role in diagnosis and treatment.

*All information is strictly confidential.*

## I. General Patient Information

Date: \_\_\_/\_\_\_/\_\_\_ Name: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_

State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: (\_\_\_\_\_) \_\_\_\_\_ Work Phone: (\_\_\_\_\_) \_\_\_\_\_

Email Address: \_\_\_\_\_

Age: \_\_\_\_\_ Date of Birth: \_\_\_/\_\_\_/\_\_\_ Place of Birth: \_\_\_\_\_

Guardian (if under 18): \_\_\_\_\_

Gender: [  ] M [  ] F Height: \_\_\_' \_\_\_" Weight: \_\_\_\_\_ lbs.

Emergency Contact: \_\_\_\_\_ Phone: (\_\_\_\_\_) \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Does anything limit you from care? [  ] Y [  ] N If yes, explain: \_\_\_\_\_

How did you hear about our office? \_\_\_\_\_

Other physicians/therapists seen for this condition: \_\_\_\_\_

Medications (if any): \_\_\_\_\_

Prescribed by: \_\_\_\_\_

Treatment:

Results:

Supplements (if any vitamins, herbs, minerals, etc): \_\_\_\_\_

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

Major Complaint(s), in order of significance to you:

	Severe	Moderate	Slight	Normal	
1.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
2.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
3.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
4.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
<hr/>					
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

How do these conditions impair your daily activities? \_\_\_\_\_

\_\_\_\_\_

## II. Patient Medical History

How was your childhood health? \_\_\_\_\_

Hospital Visits/Stays: \_\_\_\_\_

Recent tests: (please indicate test results and date below)

Physical                       Cholesterol                       Prostate                       Blood (which?)

HIV/STD                       Pap Smear                       Mammography

Other: \_\_\_\_\_

Test Results and Date: \_\_\_\_\_

Check any you had had in the past:

- |   |  |  |   |
|---|--|--|---|
| <input type="checkbox"/> Diabetes               | <input type="checkbox"/> Allergies             | <input type="checkbox"/> Glaucoma                | <input type="checkbox"/> Rheumatic Fever        |
| <input type="checkbox"/> Heart Disease          | <input type="checkbox"/> CVA (stroke)          | <input type="checkbox"/> Vein condition          | <input type="checkbox"/> Thyroid disorder       |
| <input type="checkbox"/> Asthma                 | <input type="checkbox"/> Pneumonia             | <input type="checkbox"/> Tuberculosis            | <input type="checkbox"/> Emphysema              |
| <input type="checkbox"/> Jaundice               | <input type="checkbox"/> Gonorrhea             | <input type="checkbox"/> Mumps                   | <input type="checkbox"/> Bleeding tendency      |
| <input type="checkbox"/> Syphilis               | <input type="checkbox"/> Measles               | <input type="checkbox"/> Chicken pox             | <input type="checkbox"/> Nervous disorder       |
| <input type="checkbox"/> Meningitis             | <input type="checkbox"/> HIV                   | <input type="checkbox"/> Polio                   | <input type="checkbox"/> Mononucleosis          |
| <input type="checkbox"/> Epilepsy               | <input type="checkbox"/> High fever            | <input type="checkbox"/> Hepatitis               | <input type="checkbox"/> Multiple Sclerosis     |
| <input type="checkbox"/> Paralysis              | <input type="checkbox"/> Cancer                | <input type="checkbox"/> Migraines               | <input type="checkbox"/> High blood pressure    |
| <input type="checkbox"/> other lung illnesses   | <input type="checkbox"/> other liver illnesses | <input type="checkbox"/> other heart illnesses   | <input type="checkbox"/> other kidney illnesses |
| <input type="checkbox"/> other spleen illnesses |  | <input type="checkbox"/> other stomach illnesses |   |
| <input type="checkbox"/> other: _____           |  |  |   |

Immunizations: \_\_\_\_\_

Surgeries: \_\_\_\_\_

**III. Family History**

Family member	Alive	Deceased	Present health or cause of death
Father	<input type="checkbox"/>	<input type="checkbox"/>	
_____			
Mother	<input type="checkbox"/>	<input type="checkbox"/>	
_____			
Spouse	<input type="checkbox"/>	<input type="checkbox"/>	
_____			
Children	<input type="checkbox"/>	<input type="checkbox"/>	
_____			
Brother	<input type="checkbox"/>	<input type="checkbox"/>	
_____			
Brother	<input type="checkbox"/>	<input type="checkbox"/>	
_____			
Brother	<input type="checkbox"/>	<input type="checkbox"/>	
_____			
Sister	<input type="checkbox"/>	<input type="checkbox"/>	
_____			
Sister	<input type="checkbox"/>	<input type="checkbox"/>	
_____			
Sister	<input type="checkbox"/>	<input type="checkbox"/>	
_____			

Where are you in the birth order?  first  last  middle  only  
 Check the following that have occurred in your blood relatives:

- |   |                                       |  |  |
|---|---------------------------------------|--|--|
| <input type="checkbox"/> Diabetes       | <input type="checkbox"/> Cancer       | <input type="checkbox"/> Heart Disease   | <input type="checkbox"/> High blood pressure |
| <input type="checkbox"/> Allergies      | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Obesity         | <input type="checkbox"/> Bleeding tendency   |
| <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Alcoholism   | <input type="checkbox"/> Nervous Illness | <input type="checkbox"/> Mental illness      |
| <input type="checkbox"/> Stroke         | <input type="checkbox"/> Other _____  |  |  |

**IV. Patient Profile**

Please clearly mark any areas of pain and any scars (please indicate which of the areas are scars):

Is the pain:

- |                                   |                                       |                                 |
|-----------------------------------|---------------------------------------|---------------------------------|
| <input type="checkbox"/> Sharp    | <input type="checkbox"/> Burning      | <input type="checkbox"/> Aching |
| <input type="checkbox"/> Cramping | <input type="checkbox"/> Dull         | <input type="checkbox"/> Moving |
| <input type="checkbox"/> Fixed    | <input type="checkbox"/> Other: _____ |                                 |

Do the following lessen the pain?

- |                                   |                                       |                               |
|-----------------------------------|---------------------------------------|-------------------------------|
| <input type="checkbox"/> Pressure | <input type="checkbox"/> Cold         | <input type="checkbox"/> Heat |
| <input type="checkbox"/> Exercise | <input type="checkbox"/> Other: _____ |                               |

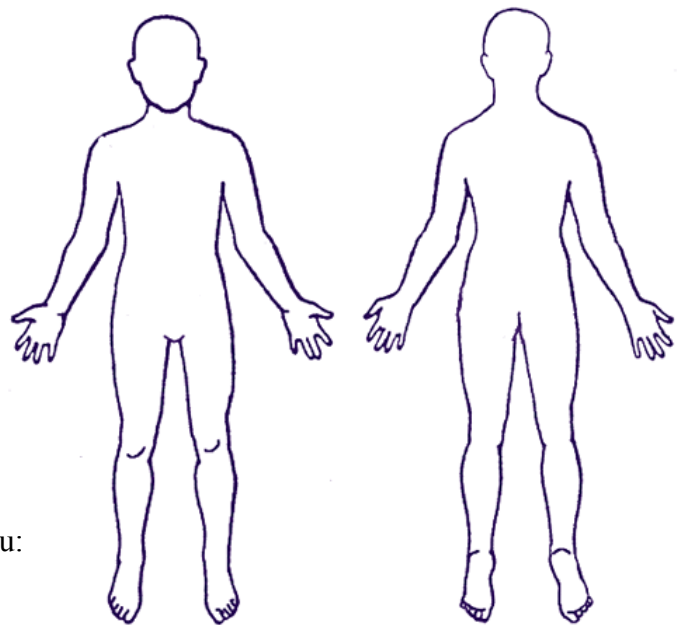
Do the following worsen the pain?

- |                                   |                                       |                               |
|-----------------------------------|---------------------------------------|-------------------------------|
| <input type="checkbox"/> Pressure | <input type="checkbox"/> Cold         | <input type="checkbox"/> Heat |
| <input type="checkbox"/> Exercise | <input type="checkbox"/> Other: _____ |                               |

Please check the following that pertain to you:

**Overall Temperature (Kidney function):**

- Cold hands
- Cold feet
- Sweaty hands
- Sweaty feet
- Hot body temperature (sensation)
- Cold body temperature (sensation)
- Afternoon flushes
- Night sweats
- Heat in the hands, feet, and chest
- Hot flashes any time of the day
- Thirsty
- Perspire easily
- Lack of perspiration
- Take water to bed
- Difficulty keeping eyes open in the daytime



Front

Back

**Overall Energy (Lung, Kidney function):**

- Shortness of breath
- Difficulty keeping eyes open in the daytime
- General weakness
- Easily catch colds
- Low energy
- Feel worse after exercise

**Blood (Liver, Spleen, Heart function):**

- Dizziness
- See floating black spots

**Heart function:**

- Palpitations
- Anxiety
- Sores on the tip of the tongue
- Restlessness
- Mental confusion
- Chest pain traveling to shoulder
- Frequent dreams
- Wake unrefreshed
- Drink coffee (# of cups per week: \_\_\_)

**Lung function:**

- Nasal Discharge (Color: \_\_\_\_\_)
- Cough
- Nose bleeds
- Sinus Congestion
- Dry mouth
- Dry throat
- Dry nose
- Dry skin
- Allergies (To what? \_\_\_\_\_)
- Alternating fever and chills
- Sneezing
- Headache (Location: \_\_\_\_\_)
- Overall achy feeling in the body
- Stiff neck
- Stiff shoulders
- Sore throat
- Difficulty breathing
- Smoke cigarettes (# of cigarettes per day: \_\_\_\_\_)
- Sadness

- Melancholy

**Spleen function:**

- Low appetite
- Abrupt weight gain
- Abrupt weight loss
- Abdominal bloating
- Abdominal gas
- Gurgling noise in the stomach
- Fatigue after eating
- Prolapsed organs (previously diagnosed, which organ? \_\_\_\_\_)
- Easily bruised
- Hemorrhoids
- Pensive
- Over-thinking
- Worry

**Spleen, Stomach, Large Intestine, Small Intestine function:**

- Loose
- Constipated
- Incomplete
- Diarrhea
- Blood in stools
- Mucous in stools
- Undigested food in stools

**Dampness trapped in the body:**

- General sensation of heaviness in the body
- Mental heaviness
- Mental sluggishness
- Mental fogginess
- Swollen hands
- Swollen feet
- Swollen joints
- Chest congestion
- Nausea
- Snoring

**Stomach function:**

- Burning sensation after eating
- Large appetite
- Bad breath
- Mouth (canker) sores

- Bleeding, swollen or painful gums
- Heartburn
- Acid regurgitation
- Ulcer (diagnosed)
- Belching
- Hiccoughs
- Stomach pain
- Vomiting

**Liver, Gall Bladder function:**

- Alternating diarrhea and constipation
- Chest pain
- Tight sensation in the chest
- Bitter taste in the mouth
- Anger easily
- Frustration
- Depression
- Irritability
- Frequently unable to adapt to stress  
(What causes the stress? \_\_\_\_\_)
- Skin rashes
- Headaches at the top of the head
- Tingling sensation
- Numbness
- Muscle spasms
- Muscle twitching
- Muscle cramping
- Seizures
- Convulsions
- Lump in the throat
- Neck tension
- Limited Range-of-Motion, Neck
- Shoulder tension
- Limited Range-of-Motion, Shoulder
- Drink alcohol
- Recreational drugs (Which?

\_\_\_\_\_,  
How much per week? \_\_\_\_\_)

- High-pitched ringing in the ears
- Gall stones (history or current)
- Sexually transmitted disease (Which?  
\_\_\_\_\_)

**Eyes (Liver function):**

- Itchy

- Bloodshot
- Hot
- Dry
- Watery
- Gritty
- Blurry vision
- Decreased night vision
- Near-sighted
- Far-sighted

**Kidney, Urinary Bladder function:**

- Frequent cavities
- 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
- Wake during the night twice or more  
to urinate
- Lack of bladder control
- Fear
- Easily startled

**Urination:**

- Normal color
- Dark yellow
- Clear
- Reddish
- Cloudy
- Scanty
- Profuse
- Strong odor
- Burning
- Painful
- Discharge
- Difficult
- Painful
- Urgent
- Frequent

**Libido:**

- Normal
- High
- Low

Other symptoms:

**Women only:**

Regular menstrual cycle  Y  N

Pregnant?  Y  N

Number of children: \_\_\_\_\_

Number of pregnancies: \_\_\_\_\_

Age of first menstruation: \_\_\_\_\_

Age of menopause (if applicable): \_\_\_\_\_

Average number of days of flow: \_\_\_\_\_

Average number of days of entire cycle: \_\_\_\_\_

	Severe	Moderate	Slight	Normal
Vaginal discharge:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding between periods:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Do you experience any of the following pre-menstrual syndromes?

- nausea
- food cravings
- depression
- vomiting
- headaches
- irritability
- water retention
- migraines
- anxiety
- breast swelling
- breast tenderness
- other emotions: \_\_\_\_\_
- dull pain, where? \_\_\_\_\_
- sharp pain, where? \_\_\_\_\_
- Other: \_\_\_\_\_

Please fill in the following menstrual chart:  
(Put in a number and what color it is)

	Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7
Color (normal, bright red, pale, brown, rust, dark, purple, other)							
Amount of flow (normal, heavy, light)							
Pain/cramps (location, dull, sharp, other)							
Clots (large, small, black, purple, red, other)							
Vomiting (check if yes)							
Nausea (check if yes)							
Other							

**Men only:**

	Severe	Moderate	Slight	Normal
<input type="checkbox"/> Swollen testes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Testicular pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Impotence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Premature ejaculation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Feeling of coldness or numbness in external genitalia	<input type="checkbox"/>	<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"/>

**All please fill out:**

Other Comments: \_\_\_\_\_  
\_\_\_\_\_

Patient Signature: \_\_\_\_\_

Acupuncturist Signature: \_\_\_\_\_