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## HEALTH HISTORY

Please take the time to fill out this questionnaire carefully. The information you provide will assist me in formulating a complete health profile for you. All your answers are absolutely confidential. If you have any questions, please ask.

If you need more room, please use the other side of these sheets.

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

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

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

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Mobile Phone: \_\_\_\_\_ E-Mail: \_\_\_\_\_

Please confirm my appointments by \_\_\_ E-Mail \_\_\_ Telephone at # \_\_\_\_\_

Date of Birth: \_\_\_/\_\_\_/\_\_\_ Age: \_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Marital Status: \_\_\_\_\_ Number of Children: \_\_\_\_\_ SS# \_\_\_-\_\_\_-\_\_\_

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

Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

In Emergency Notify: \_\_\_\_\_ Phone: \_\_\_\_\_

How did you find out about me?:  
\_\_\_\_\_

### Primary Health Concern:

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How long ago did this problem begin?

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Have you been given a diagnosis for this problem?

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To what extent does this interfere with your daily activities? (Work, sleep, exercise, sex)

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**What makes your condition better?** (Rest, movement, heat, cold, fresh air, eating, crying, etc.)

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**What makes your condition worse?** (Stress, fatigue, hunger, heat, certain foods, damp days etc.)

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**Therapies you have tried in the past:** (medication, surgery, exercise etc.)

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**Are you currently involved in any other therapies for this problem?**

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**Is this your first experience with acupuncture?** \_\_\_\_\_

**Names of any herbs or supplements you are currently taking:**

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**List any Drugs or Prescriptions you are now taking and why you are taking them:**

Prescription Drug	Reason for taking

**Significant Trauma** (physical [sports injuries, motor vehicle accidents, etc.] or emotional [deaths, divorce, loss of job, abuse, etc.]

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Surgeries (please include date of procedure)

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Allergies (chemical, environmental, food, drugs, etc.)

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**Exercise**

Days per week                      Length of workout                      Type of Activity

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**Diet**

Meals per day                      Snacks                      Caffeinated Drinks                      Alcohol per week

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Smoker \_\_\_\_\_ amount per day \_\_\_\_\_ Recreational Drugs \_\_\_\_\_ Water intake \_\_\_\_\_

**Personal History**

Please check any conditions or symptoms you have now.

- |  |   |   |   |
|--|---|---|---|
| <input type="checkbox"/> Arthritis               | <input type="checkbox"/> Liver/Gall Bladder Disease | <input type="checkbox"/> Stroke                     | <input type="checkbox"/> Heart Disease              |
| <input type="checkbox"/> High/Low Blood Pressure | <input type="checkbox"/> Hypo/Hyperglycemia         | <input type="checkbox"/> Kidney Disease             | <input type="checkbox"/> Elevated Blood Cholesterol |
| <input type="checkbox"/> Cancer                  | <input type="checkbox"/> Diabetes                   | <input type="checkbox"/> Food Allergies/Intolerance | <input type="checkbox"/> Diverticulitis/IBS         |
| <input type="checkbox"/> Ulcer                   | <input type="checkbox"/> Seizures                   | <input type="checkbox"/> Hepatitis                  | <input type="checkbox"/> Raynaud's Disease          |
| <input type="checkbox"/> Chronic Fatigue         | <input type="checkbox"/> Anemia                     | <input type="checkbox"/> Thyroid Imbalance          | <input type="checkbox"/> Respiratory Allergies      |
| <input type="checkbox"/> Alcoholism              | <input type="checkbox"/> Lyme Disease               | <input type="checkbox"/> Chronic Pain Condition     | <input type="checkbox"/> Impotence                  |
| <input type="checkbox"/> Gastritis/Pancreatitis  | <input type="checkbox"/> Asthma                     | <input type="checkbox"/> Infertility                | <input type="checkbox"/> Emphysema                  |

**Family Medical History**

Please check any condition that applies to your immediate family. Put an F (father), M (mother), S (sister), B (brother), GM (grandmother), GF (grandfather) next to choice.

- |   |   |   |                                      |
|---|---|---|--------------------------------------|
| <input type="checkbox"/> Diabetes ____            | <input type="checkbox"/> Seizures ____  | <input type="checkbox"/> Heart Disease ____ | <input type="checkbox"/> Stroke ____ |
| <input type="checkbox"/> High Blood Pressure ____ | <input type="checkbox"/> Allergies ____ | <input type="checkbox"/> Cancer ____        | <input type="checkbox"/> Asthma ____ |
| <input type="checkbox"/> Other _____              |   |   |                                      |

Please **check** if you have had any of these items listed below in the last **year**

**General**

- |   |   |  |  |
|---|---|--|--|
| <input type="checkbox"/> Change in Appetite                 | <input type="checkbox"/> Poor Sleeping      | <input type="checkbox"/> Fatigue                               | <input type="checkbox"/> Fevers                  |
| <input type="checkbox"/> Chills                             | <input type="checkbox"/> Night Sweats       | <input type="checkbox"/> Sweats Easily                         | <input type="checkbox"/> Tremors                 |
| <input type="checkbox"/> Cravings                           | <input type="checkbox"/> Localized Weakness | <input type="checkbox"/> Poor Balance                          | <input type="checkbox"/> Dental/gum problems     |
| <input type="checkbox"/> Bleed/Bruise easily                | <input type="checkbox"/> Weight loss/gain   | <input type="checkbox"/> Peculiar tastes/smells                | <input type="checkbox"/> Muscle weakness/fatigue |
| <input type="checkbox"/> Strong thirst (hot or cold drinks) |   | <input type="checkbox"/> Sudden energy drop- time of day _____ |  |

**Skin and Hair**

- |   |                                      |  |   |
|---|--------------------------------------|--|---|
| <input type="checkbox"/> Rashes             | <input type="checkbox"/> Ulcerations | <input type="checkbox"/> Hives/Allergic Dermatitis   | <input type="checkbox"/> Itching              |
| <input type="checkbox"/> Eczema/Psoriasis   | <input type="checkbox"/> Dandruff    | <input type="checkbox"/> Loss of hair                | <input type="checkbox"/> Recent moles         |
| <input type="checkbox"/> Skin discoloration | <input type="checkbox"/> Acne        | <input type="checkbox"/> Change in skin/hair texture | <input type="checkbox"/> Face flushing        |
| <input type="checkbox"/> Dermatitis         | <input type="checkbox"/> Warts       | <input type="checkbox"/> Fungal Infection            | <input type="checkbox"/> Weak or ridged nails |

## Head, Eyes, Ears, Nose and Throat

- |   |   |   |  |
|---|---|---|--|
| <input type="checkbox"/> Dizziness            | <input type="checkbox"/> Difficulty swallowing        | <input type="checkbox"/> Migraines              | <input type="checkbox"/> Glasses         |
| <input type="checkbox"/> Eye Strain           | <input type="checkbox"/> Eye pain                     | <input type="checkbox"/> Poor vision            | <input type="checkbox"/> Night Blindness |
| <input type="checkbox"/> Color Blindness      | <input type="checkbox"/> Cataracts                    | <input type="checkbox"/> Blurred vision         | <input type="checkbox"/> Earaches        |
| <input type="checkbox"/> Ringing in ears      | <input type="checkbox"/> Poor hearing                 | <input type="checkbox"/> Spots in front of eyes | <input type="checkbox"/> Sinus problems  |
| <input type="checkbox"/> Nose bleeds          | <input type="checkbox"/> Recurrent sore throats/colds | <input type="checkbox"/> Grinding teeth         | <input type="checkbox"/> Facial pain     |
| <input type="checkbox"/> Sores on lips/tongue | <input type="checkbox"/> Dental problems              | <input type="checkbox"/> Jaw clicks/locks       | <input type="checkbox"/> Headaches       |

## Cardiovascular

- |   |   |   |  |
|---|---|---|--|
| <input type="checkbox"/> Chest pain or pressure | <input type="checkbox"/> Irregular heart beat   | <input type="checkbox"/> Palpitations at rest | <input type="checkbox"/> Fainting            |
| <input type="checkbox"/> Cold hands/feet        | <input type="checkbox"/> Swelling of hands/feet | <input type="checkbox"/> Blood clots          | <input type="checkbox"/> Phlebitis           |
| <input type="checkbox"/> Shortness of breath    | <input type="checkbox"/> Varicose/spider veins  | <input type="checkbox"/> Pressure in chest    | <input type="checkbox"/> High blood pressure |
| <input type="checkbox"/> Low blood pressure     | <input type="checkbox"/> Spontaneous sweating   | <input type="checkbox"/> Dizziness            |  |

## Respiratory

- |   |  |  |  |
|---|--|--|--|
| <input type="checkbox"/> Cough/Wheezing                       | <input type="checkbox"/> Coughing blood            | <input type="checkbox"/> Asthma                                    | <input type="checkbox"/> Bronchitis              |
| <input type="checkbox"/> Pneumonia                            | <input type="checkbox"/> Pain with deep inhalation | <input type="checkbox"/> Tight sensation in chest                  | <input type="checkbox"/> Difficult inhale/exhale |
| <input type="checkbox"/> Difficulty breathing when lying down |  | <input type="checkbox"/> Production of phlegm... what color? _____ |  |

## Gastrointestinal

- |  |   |  |  |
|--|---|--|--|
| <input type="checkbox"/> Nausea              | <input type="checkbox"/> Vomiting             | <input type="checkbox"/> Diarrhea                  | <input type="checkbox"/> Constipation          |
| <input type="checkbox"/> Gas                 | <input type="checkbox"/> Belching             | <input type="checkbox"/> Black stools              | <input type="checkbox"/> Blood in stool        |
| <input type="checkbox"/> Indigestion         | <input type="checkbox"/> Bad breath           | <input type="checkbox"/> Rectal pain               | <input type="checkbox"/> Hemorrhoids           |
| <input type="checkbox"/> Bloating/Edema      | <input type="checkbox"/> Chronic laxative use | <input type="checkbox"/> Loose stools (>2 per day) | <input type="checkbox"/> Abdominal pain/cramps |
| <input type="checkbox"/> Changes in appetite | <input type="checkbox"/> Acid reflux/GERD     | <input type="checkbox"/> Hernia                    | <input type="checkbox"/> Poor appetite         |
| <input type="checkbox"/> Excessive appetite  | <input type="checkbox"/> Significant thirst   | <input type="checkbox"/> IBS/Crohn's Disease       |  |

## Genito-Urinary

- |   |   |  |  |
|---|---|--|--|
| <input type="checkbox"/> Pain on urination                                    | <input type="checkbox"/> Frequent urination | <input type="checkbox"/> Blood in urine          | <input type="checkbox"/> Urgent urination          |
| <input type="checkbox"/> Unable to hold urine                                 | <input type="checkbox"/> Kidney stones      | <input type="checkbox"/> Scanty flow             | <input type="checkbox"/> Copious flow              |
| <input type="checkbox"/> Impotence  | <input type="checkbox"/> Sores on genitals  | <input type="checkbox"/> Urinary tract infection | <input type="checkbox"/> Burning urination         |
| <input type="checkbox"/> Premature ejaculation                                | <input type="checkbox"/> Decreased libido   | <input type="checkbox"/> Prostatitis             | <input type="checkbox"/> Dribbling after urination |
| <input type="checkbox"/> Nocturnal emission                                   | <input type="checkbox"/> Pain in testicles  | <input type="checkbox"/> Herpes                  | <input type="checkbox"/> Infections                |
| <input type="checkbox"/> Night urination... What time? _____ How often? _____ |   |  | <input type="checkbox"/> Excessive libido          |

## Gynecological/Reproductive

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Difficult/Painful intercourse | <input type="checkbox"/> Ovarian cysts              | <input type="checkbox"/> Age of first menses _____           |
| <input type="checkbox"/> Vaginal dryness               | <input type="checkbox"/> Endometriosis              | <input type="checkbox"/> Date of last menses _____           |
| <input type="checkbox"/> Vaginal sores                 | <input type="checkbox"/> Uterine Fibroids           | <input type="checkbox"/> Date of last PAP/Pelvic _____       |
| <input type="checkbox"/> Vaginal discharge             | <input type="checkbox"/> Fibrocystic breast tissue  | <input type="checkbox"/> Number of pregnancies _____         |
| <input type="checkbox"/> Infertility                   | <input type="checkbox"/> Polycystic Ovarian Disease | <input type="checkbox"/> Number of ectopic pregnancies _____ |
| <input type="checkbox"/> Irregular menstruation        | <input type="checkbox"/> PMS                        | <input type="checkbox"/> Number of live births _____         |
| <input type="checkbox"/> Difficulty in conception      | <input type="checkbox"/> Painful menstruation       | <input type="checkbox"/> Number of miscarriages _____        |
| <input type="checkbox"/> Infertility treatments        | <input type="checkbox"/> Heavy flow/ clots          | <input type="checkbox"/> Number of abortions _____           |

Do you practice birth control? \_\_\_\_\_ What type? \_\_\_\_\_ How long? \_\_\_\_\_

Other gynecological issues?

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## Musculoskeletal

- |   |  |  |  |
|---|--|--|--|
| <input type="checkbox"/> Neck pain  | <input type="checkbox"/> Shoulder pain   | <input type="checkbox"/> Hand/wrist pain | <input type="checkbox"/> Carpal Tunnel   |
| <input type="checkbox"/> Knee pain  | <input type="checkbox"/> Sprains/Strains | <input type="checkbox"/> Sciatica        | <input type="checkbox"/> Foot/ankle pain |
| <input type="checkbox"/> Hip pain   | <input type="checkbox"/> Muscle pain     | <input type="checkbox"/> Muscle weakness | <input type="checkbox"/> Tendonitis      |
| <input type="checkbox"/> Back pain    Low___ Middle___ Upper___                         | <input type="checkbox"/> Bursitis        | <input type="checkbox"/> Rotator Cuff    |  |
| <input type="checkbox"/> Soreness/weakness in lower body (back, knee, hip, ankle, foot) |  |  |  |

## Neuropsychological

- |  |   |   |  |
|--|---|---|--|
| <input type="checkbox"/> Seizures              | <input type="checkbox"/> Loss of balance      | <input type="checkbox"/> Vertigo/Dizziness            | <input type="checkbox"/> Areas of numbness           |
| <input type="checkbox"/> Lack of coordination  | <input type="checkbox"/> Poor memory          | <input type="checkbox"/> Concussion                   | <input type="checkbox"/> Depression                  |
| <input type="checkbox"/> Anxiety/Panic attacks | <input type="checkbox"/> Bad temper/irritable | <input type="checkbox"/> Easily susceptible to stress | <input type="checkbox"/> Seasonal Affective Disorder |
| <input type="checkbox"/> Nervousness           | <input type="checkbox"/> ADD/ADHD             | <input type="checkbox"/> Manic Depression             |  |

Have you ever been treated for emotional problems?

Yes     No

Have you ever considered or attempted suicide?

Yes     No

Have you ever been treated for substance abuse?

Yes     No

**Comments:** Please inform me of any other problems you would like to discuss.

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**Please indicate areas of pain on drawing below:**

