HEALTH HISTORY QUESTIONNAIRE

Welcome! Please help us provide you with a complete evaluation by taking the time to fill out this questionnaire carefully. All your answers will be held absolutely confidential. If you have questions, please ask us. If there is anything you wish to bring to our attention which is not asked on this form, please note it in the COMMENTS section. Thank you!

Name:

Street: City State Zip

Age: Height: Weight:

Home Phone: Work Phone: Cell Phone:

Date/Place of Birth: Email:

Occupation: Marital Status:

In Emergency Notify:

Referred by:

Family Physician:

Have you tried acupuncture or Chinese herbal medicine before?

Please indicate your chief complaints:

To what extent does this problem affect your daily activities (work, sleep, eating, etc.)?

How long has it been since you first noticed any symptoms?

Have you been given a diagnosis for the problem by your family physician?

If so, what is it?

What kinds of treatment or therapy have you tried?

PAST MEDICAL HISTORY (PLEASE INCLUDE DATES)

- ☐ Allergies:
- ☐ Cancer
- ☐ Diabetes
- ☐ Hepatitis
- ☐ High blood pressure
- ☐ Heart disease
- ☐ Seizures
- ☐ Rheumatic fever
- ☐ Surgeries
- ☐ Venereal disease
- ☐ Thyroid disease
- ☐ Birth trauma (prolonged labor, forceps delivery, etc)
- ☐ Other significant illness (describe)
- ☐ Accidents or significant trauma (describe)

OTHER RELEVANT MEDICAL HISTORY

Family Medical History

☐ Allergies	☐ Cancer	☐ Seizures
☐ Diabetes	☐ Heart disease	☐ Stroke
☐ Asthma	☐ High blood pressure	☐ Other

Occupation

Occupational stress factors (physical, psychological, chemical):

Lifestyle

Do you follow a regular exercise program? If so, please describe:

Please describe your average daily diet:

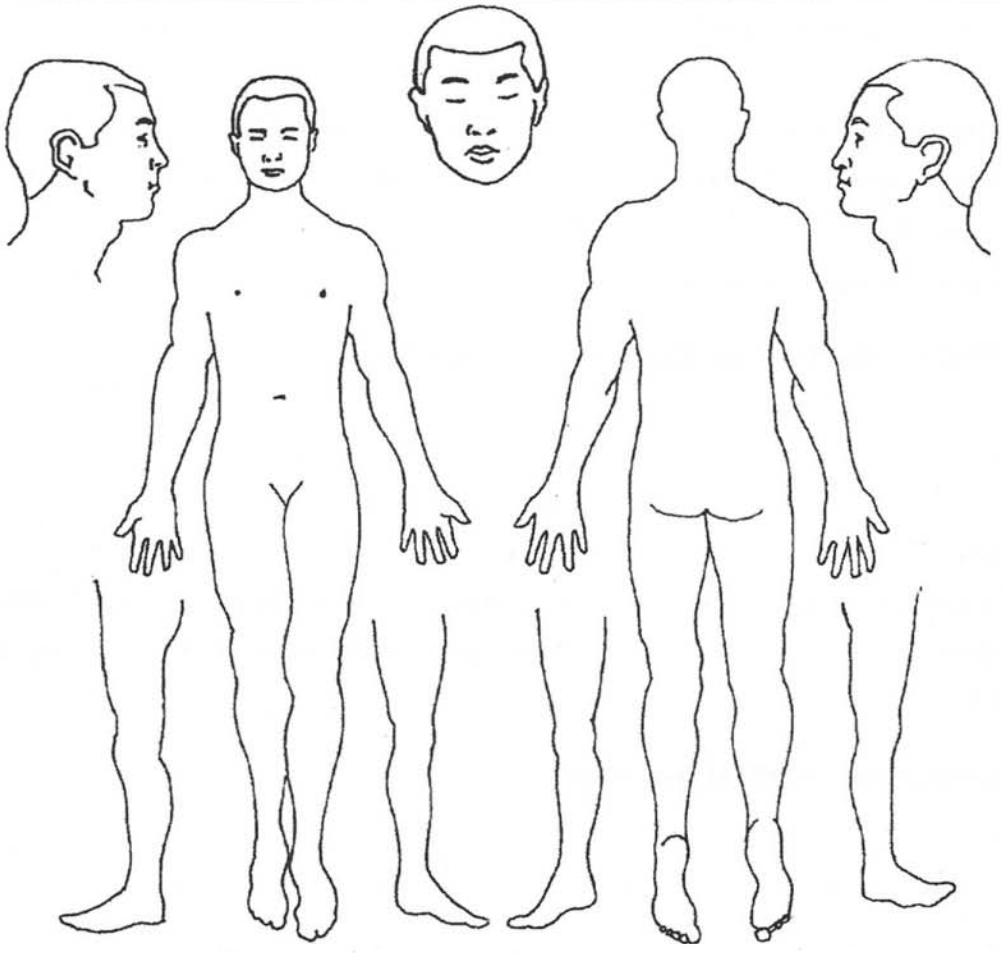
Please check any of the following habits that apply. How much and how often do you use them?

☐ Cigarette smoking ☐ Coffee, tea or cola ☐ Alcoholic beverages

List medications taken within the last two months (vitamins, drugs, herbs, etc.):

Please describe any use of drugs for non-medical purposes:

In the figures below please mark an X in all areas of concern



CHECK NEXT TO ANY CONDITIONS YOU HAVE EXPERIENCED WITHIN THE LAST THREE MONTHS. INDICATE THE LENGTH OF TIME YOU HAVE HAD THIS CONDITION

GENERAL

- ☐ Poor appetite
- ☐ Insomnia
- ☐ Disturbed sleep
- ☐ Localized weakness
- ☐ Cravings
- ☐ Strong thirst
- ☐ Weight gain
- ☐ Weight loss
- ☐ Changes in appetite
- ☐ Sweating easily
- ☐ Tremors
- ☐ Bleeding or bruising easily
- ☐ Night sweats
- ☐ Fever
- ☐ Chills
- ☐ Sudden energy drop (time of day?)
- ☐ Poor balance

Other unusual or abnormal conditions you have noticed in your general sense of health

SKIN AND HAIR

- ☐ Rashes
- ☐ Ulcerations
- ☐ Hives
- ☐ Itching
- ☐ Eczema
- ☐ Pimples
- ☐ Dandruff
- ☐ Hair loss
- ☐ Recent moles
- ☐ Changes in texture of hair or skin

Any other hair or skin problems

HEAD, EYES, EARS, NOSE, THROAT

- ☐ Dizziness
- ☐ Concussions
- ☐ Migraines
- ☐ Glasses
- ☐ Spots in front of eyes
- ☐ Eye pain
- ☐ Poor vision
- ☐ Night blindness
- ☐ Color blindness
- ☐ Cataracts
- ☐ Blurry vision
- ☐ Earaches
- ☐ Ringing in ears
- ☐ Poor hearing
- ☐ Eye strain
- ☐ Sinus problems
- ☐ Recurrent sore throats
- ☐ Nose bleeds
- ☐ Grinding teeth
- ☐ Sores on lips or tongue
- ☐ Facial pain
- ☐ Teeth problems
- ☐ Headaches (where? when?)
- ☐ Jaw clicks

Any other head or neck problems

CARDIOVASCULAR

- ☐ Dizziness
- ☐ Low blood pressure
- ☐ Chest pain
- ☐ Irregular heartbeat
- ☐ High blood pressure
- ☐ Fainting
- ☐ Cold hands or feet
- ☐ Swelling of hands
- ☐ Swelling of feet
- ☐ Blood clots
- ☐ Difficulty in breathing
- ☐ Phlebitis

Any other heart or blood vessel problems

RESPIRATORY

- ☐ Cough
- ☐ Coughing up blood
- ☐ Asthma
- ☐ Bronchitis
- ☐ Pain with deep inhalation
- ☐ Pneumonia
- ☐ Difficulty breathing when lying down
- ☐ Excessive phlegm (color?)

Any other lung problems

GASTROINTESTINAL

- ☐ Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Gas
- ☐ Belching
- ☐ Black stools
- ☐ Blood in stools
- ☐ Indigestion
- ☐ Bad breath
- ☐ Rectal pain
- ☐ Hemorrhoids
- ☐ Abdominal pain or cramps
- ☐ Chronic laxative use

Any other problems with stomach or intestines

GENITOURINARY

- ☐ Pain on urination
- ☐ Urgent or frequent urination
- ☐ Blood in urine
- ☐ Unable to hold urine
- ☐ Decrease in flow
- ☐ Kidney stones
- ☐ Prostate problems
- ☐ Impotence
- ☐ Sores on genitals

Do you wake up at night to urinate? If so, how often?

Any particular color to your urine?

Any other genital or urinary problems

REPRODUCTIVE AND GYNECOLOGIC

- ☐ Premenstrual changes
- ☐ Menstrual clots
- ☐ Painful menses
- ☐ Unusual menses
- ☐ Heavy menstrual flow
- ☐ Light menstrual flow
- ☐ Irregular menses
- ☐ Other problems
- ☐ Premature births
- ☐ Miscarriages
- ☐ Abortions

Age at first menses Age at menopause Number of pregnancies

Time between cycles Duration of bleeding First day of last menses

Do you practice birth control? If so, what type? For how long?

Any other gynecologic problems

MUSCULOSKELETAL

- ☐ Neck pain
- ☐ Muscle pains
- ☐ Knee pain
- ☐ Back pain
- ☐ Muscle weakness
- ☐ Foot/ankle pains
- ☐ Hand/wrist pains
- ☐ Shoulder pains
- ☐ Hip pain

Any other joint or bone problems

NEUROPSYCHOLOGICAL

- ☐ Seizures
- ☐ Dizziness
- ☐ Loss of balance
- ☐ Areas of numbness
- ☐ Poor memory
- ☐ Lack of coordination
- ☐ Concussion
- ☐ Depression
- ☐ Anxiety
- ☐ Bad temper
- ☐ Easily susceptible to stress

Have you ever been treated for emotional problems?

Have you ever considered or attempted suicide?

Any other neurological or psychological problems

COMMENTS

Please list any other problems you would like to discuss: