# *Health History Questionnaire*

***Information for your Acupuncturist***

Important: 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/Cell Phone: (_______) _________________

Email Address: ____________________________________________________

Age: _________ Date of Birth: _____/_____/_____ Place of Birth: ______________________________

Guardian: (if under 18) ______________________________________________________

Gender: ( ) M ( ) F Height: _______ Weight: _______

Occupation: ___________________________________ Employer: ___________________________________

Employer Address: ______________________________________________________

City: ________________________________ State: ______________________________________ Zip: ________________

Does anything limit you from care? ( ) Y ( ) N If yes explain: ______________________________

How did you hear about our office? ______________________________________________

Other physicians/therapists seen: ______________________________________________

Treatments: ______________________________________________________________

All medications currently taken: ______________________________________________

Prescribed by: ______________________________________________________________

Results: ______________________________________________________________

Supplements: (vitamins, herbs, minerals, etc.): __________________________________

______________________________________________________________________________

May we contact your Doctor? [__] Y__[___] N ____________Phone Number____________________________________

# Major Complaints

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

| | Severe | Moderate | Slight | Normal | |
|---|---|---|---|---|---|
| 1. | ☐ | ☐ | ☐ | ☐ | ____________________ |
| 2. | ☐ | ☐ | ☐ | ☐ | ____________________ |
| 3. | ☐ | ☐ | ☐ | ☐ | ____________________ |
| 4. | ☐ | ☐ | ☐ | ☐ | ____________________ |
| 5. | ☐ | ☐ | ☐ | ☐ | ____________________ |
| 6. | ☐ | ☐ | ☐ | ☐ | ____________________ |
| 7. | ☐ | ☐ | ☐ | ☐ | ____________________ |
| 8. | ☐ | ☐ | ☐ | ☐ | ____________________ |
| 9. | ☐ | ☐ | ☐ | ☐ | ____________________ |
| 10. | ☐ | ☐ | ☐ | ☐ | ____________________ |

How do these complaints impair daily activities? ____________________

____________________

____________________

Check any you have had in the past:

| | | | |
|---|---|---|---|
| ☐ Diabetes | ☐ Allergies | ☐ Glaucoma | ☐ Rheumatic Fever |
| ☐ Heart Disease | ☐ CVA (stroke) | ☐ Vein condition | ☐ Thyroid disorder |
| ☐ Asthma | ☐ Pneumonia | ☐ Tuberculosis | ☐ Emphysema |
| ☐ Jaundice | ☐ Amenorrhea | ☐ Mumps | ☐ Bleeding tendency |
| ☐ Syphilis | ☐ Measles | ☐ Chicken Pox | ☐ Nervous disorder |
| ☐ Meningitis | ☐ HIV | ☐ Polio | ☐ Mononucleosis |
| ☐ Epilepsy | ☐ High fever | ☐ Hepatitis | ☐ Multiple Sclerosis |
| ☐ Paralysis | ☐ Cancer | ☐ Migraines | ☐ High blood pressure |
| ☐ other lung illnesses | ☐ other liver illnesses | ☐ other heart illnesses | ☐ other kidney illnesses |
| ☐ Other spleen illnesses | | ☐ other stomach illnesses | |

Immunizations: ____________________________________________________________________

Surgeries: ________________________________________________________________________

___________________________________________________________________________________

**III. Family History**

| Family member | Alive | Deceased | Present health or cause of death |
|---|---|---|---|
| Father | ☐ | ☐ | ______________________ |
| Mother | ☐ | ☐ | ______________________ |
| Spouse | ☐ | ☐ | ______________________ |
| Children | ☐ | ☐ | ______________________ |
| Brother | ☐ | ☐ | ______________________ |
| Brother | ☐ | ☐ | ______________________ |
| Brother | ☐ | ☐ | ______________________ |
| Sister | ☐ | ☐ | ______________________ |
| Sister | ☐ | ☐ | ______________________ |
| Sister | ☐ | ☐ | ______________________ |

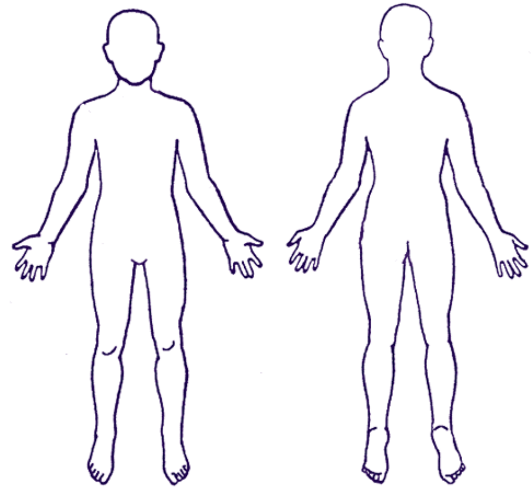
Where are you in the birth order? ☐ first ☐ middle ☐ last ☐ only

Check the following that have occurred in your blood relatives:

| | | | |
|---|---|---|---|
| ☐ Diabetes | ☐ Cancer | ☐ Heart disease | ☐ High blood pressure |
| ☐ Allergies | ☐ Tuberculosis | ☐ Obesity | ☐ Bleeding tendency |
| ☐ Kidney disease | ☐ Alcoholism | ☐ Nervous illness | ☐ Mental illness |
| ☐ Stroke | ☐ Other | | |

**IV. Patient Profile**

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



Is the pain:

- □ Sharp
- □ Burning
- □ Aching
- □ Cramping
- □ Dull
- □ Moving
- □ Fixed
- □ Other ___________________

Do the following lessen the pain?

- □ Pressure
- □ Cold
- □ Heat
- □ Exercise
- □ Other _____________________

Do the following worsen the pain?

- □ Pressure
- □ Cold
- □ Heat
- □ Exercise
- □ 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 anytime of the day
- □ Thirsty
- □ Perspire easily
- □ Lack of perspiration
- □ Take water to bed
- □ Sweaty hands
- □ Difficulty keeping eyes open in the day time

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

- □ Shortness of breath
- □ Difficulty keeping eyes open in the day time
- □ Easily catch colds
- □ General weakness
- □ Low energy
- □ Feel worse after exercising

**Heart function:**

- □ Palpations
- □ Anxiety
- □ Sores on the tip of the tongue
- □ Mental confusion
- □ Chest pain traveling to shoulder
- □ Frequent dreams
- □ Wake unrefreshed
- □ Drink coffee (# of cups/week _____)

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

- □ Dizziness
- □ See floating black spots

**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

**Lung function:**
- ☐ Nasal discharge (color ________)
- ☐ Cough
- ☐ Nose bleeds
- ☐ 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 shoulder
- ☐ Sore throat
- ☐ Difficulty breathing
- ☐ Smoke cigarettes (# of cigarettes/day____)
- ☐ Sadness
- ☐ Melancholy

**Spleen function:**
- ☐ Abrupt weight gain
- ☐ Low appetite
- ☐ Abrupt weight loss
- ☐ Abdominal bloating
- ☐ Abdominal gas
- ☐ Gurgling noise in the stomach
- ☐ Fatigue after eating
- ☐ Prolapsed organs (previously diagnosed____________)
- ☐ 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

**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 pains
- ☐ Vomiting

**Liver, Gallbladder 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 kind of stress? _________________)
- ☐ Skin rashes
- ☐ Headache at the top of the head
- ☐ Tingling sensations
- ☐ Numbness
- ☐ Muscle spasms
- ☐ Muscle twitching
- ☐ Muscle cramping
- ☐ Seizures
- ☐ Convulsion
- ☐ Lump in throat
- ☐ Neck tension
- ☐ Limited range of motion, Neck
- ☐ Shoulder tension
- ☐ Limited range of motion, Shoulder
- ☐ Drink alcohol
- ☐ Recreational drugs (Which? _______________)
- ☐ High-pitched ringing in ears
- ☐ Gall stones (history or current)

**Eyes: (Liver function)**
- □ Itchy
- □ Bloodshot
- □ Hot
- □ Dry
- □ Watery
- □ Gritty
- □ Blurred vision
- □ Decreased night vision
- □ Near-sighted
- □ Far-sighted

**Kidney, Urinary, Bladder function**
- □ Frequent cavities
- □ Easily broken bones
- □ Sore knees
- □ Weak knees
- □ Cold sensation in knees
- □ Low back pain
- □ Memory problems
- □ Excessive hair loss
- □ Low-pitched ringing in the ears
- □ Kidney stones
- □ Bladder infections
- □ Wake during night twice or more
- □ 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
- □ Frequency

**Libido:**
- □ Normal
- □ High
- □ Low

**Other symptoms:**

**Women only:**

Regular menstrual cycle? □ Y □ N
Number of children: ________
Age of first menstruation:________
Average number of days of flow:___________

Pregnant? □ Y □ N
Number of pregnancies:__________
Age of menopause (if applicable)__________
Average number of days of entire cycle_________

| | Severe | Moderate | Slight | Normal |
|---|---|---|---|---|
| Vaginal discharge | □ | □ | □ | □ |
| Bleeding between period | □ | □ | □ | □ |

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

□ nausea □ food cravings □ depression □ vomiting

□ headaches □ irritability □ water retention □ migraines

□ anxiety □ breast swelling □ breast tenderness

□ other emotions_________________________ □ dull pain, where?__________________

□ sharp pain, where? ______________________________________________

| Menstrual Chart | 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)<br>Nausea ◻ (check if yes) | | | | | | | |
| Other | | | | | | | |

**Men only:**

| | Severe | Moderate | Slight | Normal |
|---|---|---|---|---|
| ◻ Swollen testes | ◻ | ◻ | ◻ | ◻ |
| ◻ Testicular pain | ◻ | ◻ | ◻ | ◻ |
| ◻ Impotence | ◻ | ◻ | ◻ | ◻ |
| ◻ Premature ejaculation | ◻ | ◻ | | |
| ◻ Felling of coldness or numbness in external genitilia | ◻ | ◻ | ◻ | ◻ |
| ◻ Other ____________________________ | | | | |

**All please fill out:**

Other Comments: ______________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

Patient Signature: ________________________________________

Acupuncturist Signature: __________________________________