

NAPERVILLE ACUPUNCTURE CENTER
Traditional Chinese Medicine Clinic

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.

Date: _____ Name: _____

Address: _____ City, State, Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Age: _____ Date of Birth: _____ Place of Birth : _____

Email: _____ Emergency Contact (name and number): _____

Legal Guardian (if under 18): _____

Gender: M F Height: _____ Weight: _____ lbs. Occupation: _____

Employer: _____ How did you hear about us? _____

Employer Address: _____ City, State, Zip: _____

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

Other physicians/therapists seen for this condition: _____

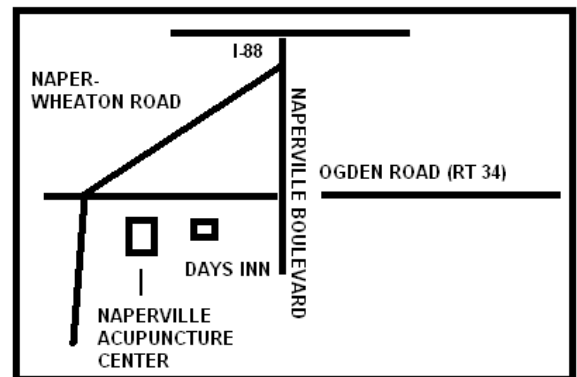
List all medications currently taken (attach sheet if necessary): _____

List all dietary supplements (vitamins, herbs, etc.) taken: _____

FINDING OUR CLINIC

We are located on the south side of the street, across from Fair Oaks Ford, just west of the intersection of Ogden and Naperville Boulevard. Our clinic and parking are located in the back of the building.

We require 24 hours notice of cancellation if you are unable to keep your appointment.



1324 EAST OGDEN SUITE 102, NAPERVILLE, IL 60563 630.369.3237

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I. MAJOR COMPLAINTS

Please list major complaints, 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"/>	_____
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 complaints impair daily activities? _____

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

Mark all that describe your pain:

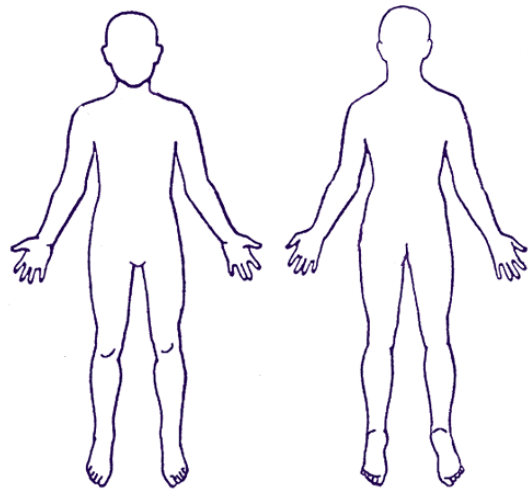
- Sharp
- Cramping
- Fixed
- Burning
- Dull
- Other _____
- Aching
- Moving

Do the following lessen the pain?

- Pressure
- Exercise
- Cold
- Other _____
- Heat

Do the following worsen the pain?

- Pressure
- Exercise
- Cold
- Other _____
- Heat



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II. PATIENT MEDICAL HISTORY

How was your childhood health? _____

Hospital Visits/Stays: _____

Recent Tests: (Please indicate test results and dates below)

- | | | | | |
|------------------------------------|--------------------------------------|-----------------------------------|---|---------------------------------------|
| <input type="checkbox"/> Physical | <input type="checkbox"/> Cholesterol | <input type="checkbox"/> Prostate | <input type="checkbox"/> Blood (Which?) | <input type="checkbox"/> HIV/STD |
| <input type="checkbox"/> Pap Smear | <input type="checkbox"/> Mammography | <input type="checkbox"/> MRI | <input type="checkbox"/> X Ray | <input type="checkbox"/> Other: _____ |

Test dates and Results: _____

Check any you have had in the past

- | | | | |
|---|--|--|---|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Allergies | <input type="checkbox"/> Vein condition | <input type="checkbox"/> Thyroid disorder |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> CVA (stroke) | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Emphysema |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Mumps | <input type="checkbox"/> Bleeding tendency |
| <input type="checkbox"/> Jaundice | <input type="checkbox"/> Amenorrhea | <input type="checkbox"/> Chicken pox | <input type="checkbox"/> Nervous disorder |
| <input type="checkbox"/> Syphilis | <input type="checkbox"/> Measles | <input type="checkbox"/> Polio | <input type="checkbox"/> Mononucleosis |
| <input type="checkbox"/> Meningitis | <input type="checkbox"/> HIV | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Multiple Sclerosis |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> High Fever | <input type="checkbox"/> Migraines | <input type="checkbox"/> Kidney disease |
| <input type="checkbox"/> Paralysis | <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart disease | |
| <input type="checkbox"/> Lung disease | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Stomach disease | |
| <input type="checkbox"/> Spleen disease | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Rheumatic fever | |

Immunizations: _____

Surgeries/dates: _____

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 were you in the birth order? _____

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Check the following that have occurred in your blood relatives:

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

IV. TRADITIONAL CHINESE MEDICINE

YIN/YANG BALANCE

- | | | |
|---|---|---|
| <input type="checkbox"/> Cold hands | <input type="checkbox"/> Sweaty hands | <input type="checkbox"/> Heat in hands, feet, and chest |
| <input type="checkbox"/> Cold feet | <input type="checkbox"/> Sweaty feet | <input type="checkbox"/> Thirsty |
| <input type="checkbox"/> Cold body (temperature sensation) | <input type="checkbox"/> Hot body (temperature sensation) | <input type="checkbox"/> Perspire easily |
| <input type="checkbox"/> Purple Hands/Feet | <input type="checkbox"/> Afternoon flushes | <input type="checkbox"/> Lack of perspiration |
| <input type="checkbox"/> Difficult keeping eyes open in daytime | <input type="checkbox"/> Night sweats | <input type="checkbox"/> Thirsty at night |

QI/ENERGY

- | | | |
|--|---|--|
| <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> General Weakness | <input type="checkbox"/> Feel worse after exercising |
| <input type="checkbox"/> Easily catch colds | <input type="checkbox"/> Low Energy | |

BLOOD

- | | | | |
|--|--|------------------------------------|--|
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Numbness | <input type="checkbox"/> Cramping | <input type="checkbox"/> Skin Rash |
| <input type="checkbox"/> Muscle Weakness | <input type="checkbox"/> Fixed, stabbing pains | <input type="checkbox"/> Twitching | <input type="checkbox"/> Varicose veins |
| <input type="checkbox"/> Tingling | <input type="checkbox"/> Spasms | <input type="checkbox"/> Dry skin | <input type="checkbox"/> Bruise/bleed easily |

DAMPNESS

- | | |
|--|--|
| <input type="checkbox"/> Swollen hands (with heat/redness? () Y () N) | <input type="checkbox"/> Mental heaviness |
| <input type="checkbox"/> Swollen feet (with heat/redness? () Y () N) | <input type="checkbox"/> Mental sluggishness |
| <input type="checkbox"/> Swollen joints (with heat/redness? () Y () N) | <input type="checkbox"/> Chest congestion |
| <input type="checkbox"/> General sensation of heaviness in the body | <input type="checkbox"/> Nausea |
| <input type="checkbox"/> Snoring | <input type="checkbox"/> Vertigo |

LUNG FUNCTION

- | | |
|--|--|
| <input type="checkbox"/> Nasal discharge (color _____) | <input type="checkbox"/> Sneezing |
| <input type="checkbox"/> Cough | <input type="checkbox"/> Sore throat |
| <input type="checkbox"/> Dry mouth | <input type="checkbox"/> Difficulty breathing |
| <input type="checkbox"/> Dry throat | <input type="checkbox"/> Smoke cigarettes (of cigarettes/day _____) |
| <input type="checkbox"/> Dry nose | <input type="checkbox"/> Cold sores |
| <input type="checkbox"/> Allergies (to what? _____) | |

SPLEEN FUNCTION

- | | |
|--|---|
| <input type="checkbox"/> Abrupt weight gain | <input type="checkbox"/> Fatigue after eating |
| <input type="checkbox"/> Low appetite | <input type="checkbox"/> Prolapsed organs (previously diagnosed _____) |
| <input type="checkbox"/> Abrupt weight loss | <input type="checkbox"/> Easily bruised |
| <input type="checkbox"/> Abdominal bloating | <input type="checkbox"/> Hemorrhoids |
| <input type="checkbox"/> Abdominal gas | <input type="checkbox"/> Over thinking |
| <input type="checkbox"/> Gurgling noise in stomach | <input type="checkbox"/> Worry |

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STOMACH FUNCTION

- | | |
|--|---|
| <input type="checkbox"/> Burning sensation, after eating | <input type="checkbox"/> Acid regurgitation |
| <input type="checkbox"/> Burning sensation, relieved by eating | <input type="checkbox"/> Ulcer (diagnosed) |
| <input type="checkbox"/> Bad breath | <input type="checkbox"/> Belching |
| <input type="checkbox"/> Mouth (canker) sores | <input type="checkbox"/> Hiccups |
| <input type="checkbox"/> Bleeding, swollen, painful gums | <input type="checkbox"/> Stomach pains |
| <input type="checkbox"/> Heartburn | <input type="checkbox"/> Vomiting |
| <input type="checkbox"/> Use antacids | |

INTESTINAL FUNCTION

- | | | |
|--------------------------------------|--|--|
| <input type="checkbox"/> Constipated | <input type="checkbox"/> Loose bowels | <input type="checkbox"/> Mucus in stools |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Blood in stools | <input type="checkbox"/> Undigested food in stools |

LIVER/GALLBLADDER FUNCTION

- | | |
|--|--|
| <input type="checkbox"/> Alternating diarrhea and constipation | <input type="checkbox"/> Lump in throat |
| <input type="checkbox"/> Chest pain | <input type="checkbox"/> Tension in neck and shoulders |
| <input type="checkbox"/> Tight sensation in chest | <input type="checkbox"/> Limited range of motion, neck |
| <input type="checkbox"/> Bitter taste in mouth | <input type="checkbox"/> Drink alcohol |
| <input type="checkbox"/> Anger Easily | <input type="checkbox"/> Hypertension |
| <input type="checkbox"/> Frustration | <input type="checkbox"/> High-pitch ringing in ears (which one(s)? _____) |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Gall stones (History or current) |
| <input type="checkbox"/> Irritability | <input type="checkbox"/> Use recreational drugs (which one(s)? _____) |
| <input type="checkbox"/> Headache at top of the head | <input type="checkbox"/> Frequently unable to adapt to stress (What kind of stress? _____) |
| <input type="checkbox"/> Headache at temples/behind eyes | |
| <input type="checkbox"/> Headache on forehead | |

HEART FUNCTION

- | | | |
|---------------------------------------|---|---|
| <input type="checkbox"/> Rapid pulse | <input type="checkbox"/> Sores on tip of tongue | <input type="checkbox"/> Frequent dreams |
| <input type="checkbox"/> Palpitations | <input type="checkbox"/> Mental confusion | <input type="checkbox"/> Wake unrefreshed |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Chest pain traveling to shoulder | |

EYES (LIVER FUNCTION)

- | | | |
|------------------------------------|---------------------------------|---|
| <input type="checkbox"/> Itchy | <input type="checkbox"/> Dry | <input type="checkbox"/> Blurred vision |
| <input type="checkbox"/> Bloodshot | <input type="checkbox"/> Watery | <input type="checkbox"/> Decreased night vision |
| <input type="checkbox"/> Hot | <input type="checkbox"/> Gritty | |

KIDNEY FUNCTION

- | | | |
|--|--|--|
| <input type="checkbox"/> Frequent cavities | <input type="checkbox"/> Memory problems | <input type="checkbox"/> Wake during night twice or more |
| <input type="checkbox"/> Easily broken bones | <input type="checkbox"/> Excessive hair loss | <input type="checkbox"/> Lack of bladder control |
| <input type="checkbox"/> Sore knees | <input type="checkbox"/> Low-pitched ringing in ears | <input type="checkbox"/> Fear |
| <input type="checkbox"/> Cold sensation in knees | <input type="checkbox"/> Kidney stones | <input type="checkbox"/> Easily startled |
| <input type="checkbox"/> Low back pain | <input type="checkbox"/> Bladder infections | |

BLADDER FUNCTION (URINATION)

- | | | | |
|--------------------------------------|----------------------------------|------------------------------------|------------------------------------|
| <input type="checkbox"/> Dark yellow | <input type="checkbox"/> Cloudy | <input type="checkbox"/> Burning | <input type="checkbox"/> Difficult |
| <input type="checkbox"/> Clear | <input type="checkbox"/> Scanty | <input type="checkbox"/> Painful | <input type="checkbox"/> Urgent |
| <input type="checkbox"/> Reddish | <input type="checkbox"/> Profuse | <input type="checkbox"/> Discharge | <input type="checkbox"/> Frequent |

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LIBIDO

Normal High Low

V. WOMEN'S HEALTH

Check any of the following conditions that apply:

Polycystic Ovaries Uterine Fibroids Endometriosis

Have you had a hysterectomy? Y N

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 period	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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 <input type="checkbox"/> (check if yes) Nausea <input type="checkbox"/> (check if yes)							
Other							

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VI. MEN'S HEALTH

	Severe	Moderate	Slight	Normal
Swollen testes	<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"/>
Impotence	<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"/>
Coldness or numbness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Other _____

VII. PATIENT'S GOALS

Have you had acupuncture before? Y N

Check treatment goals you are interested in:

- Temporary relief of symptoms/pain control
- Eliminate root or cause of problem (if possible)
- Lessen/eliminate habits which caused the condition or made it worse
- Maintenance care (periodic balancing/tune-up to keep in good health)

Are you interested in learning more about losing weight? Y N

Are you interested in learning more about detoxification? Y N

Do you have any other expectations about acupuncture and your visit with our office? _____

Other Comments: _____

Patient Signature: _____

Acupuncturist Signature: _____