

HEALTH HISTORY

This is a **CONFIDENTIAL** questionnaire to help us determine the best treatment plan for you.

Name _____ Date _____

Home Address _____ City _____

State __ Zip_____ Email _____ Home Phone _____ Work _____

Occupation _____ Person responsible for your account _____

Emergency Contact _____ Phone _____

Who can we thank for referring you? _____

Sex: M___F___ Height: _____ Weight: _____ Birth Date: _____ Age: _____

Marital Status: Married Single Divorced Widowed Number of children: _____

Previous Acupuncture? Y or N When? _____ With whom? _____

Please circle yes or no (leave blank if uncertain) any significant illnesses you or a blood relative (parent, grandparent or sibling) have had:

			Relationship				Relationship
Cancer	N	Y	_____	Diabetes	N	Y	_____
Hepatitis	N	Y	_____	Heart Disease	N	Y	_____
High blood pressure	N	Y	_____	Seizures	N	Y	_____
Rheumatic Fever	N	Y	_____	Tuberculosis	N	Y	_____
Emotional Disorders	N	Y	_____	Stroke	N	Y	_____
Infectious Diseases	N	Y	_____	High Cholesterol	N	Y	_____
Obesity	N	Y	_____	Migraines	N	Y	_____
Drug/Alcohol Problems	N	Y	_____	Asthma	N	Y	_____

Sexually Transmitted Diseases: gonorrhea syphilis HIV HPV chlamydia herpes Date: _____

Please circle with a yes or no the use and frequency of the following:

			Amount				Amount
Coffee/Black Tea	N	Y	_____	Tobacco	N	Y	_____
Recreational drugs	N	Y	_____	Water Intake	N	Y	_____
Alcohol	N	Y	_____	Soda	N	Y	_____

Please circle no or yes to the following statements:

I have known allergies	N	Y
I am taking Coumadin/Warfarin	N	Y
I have a pacemaker	N	Y
I am taking Lithium (Eskalith, Lithoid, Lithonate, Lithotabs)	N	Y

***List all medications and supplements you are currently taking:
(Continue on back if needed)***

Medicine	Dosage	Reason	How Long	Prescribed by	Date last checkup

What are the main health problems for which you are seeking treatment?

What other forms of treatment have you sought? _____

List any other health problems you now have. _____

List any allergies (foods, drugs, food sensitivities or food cravings that you have. _____

List any accidents, surgeries, or hospitalizations (include date). _____

Practitioner's Use Only

- | | | | |
|--|--|------------------------------------|--|
| <input type="checkbox"/> Onset | <input type="checkbox"/> Location | <input type="checkbox"/> Duration | <input type="checkbox"/> Characteristics |
| <input type="checkbox"/> Aggravate/Allev | <input type="checkbox"/> Related Factors | <input type="checkbox"/> Treatment | <input type="checkbox"/> Significance |

How do you feel about the following areas of your life?

Check the appropriate boxes and indicate any problems you may be experiencing

	Great	Good	Fair	Poor	Bad	Your Comments
Significant other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Family	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Sex	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Self	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Work	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Exercise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Spirituality	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

FOR WOMEN

Age of 1st period (menarche) _____ Are you Pregnant? Y or N # of pregnancies _____
 Age of last period (menopause) _____ # of live births _____ # of Abortions _____

of Miscarriages _____
 Date of last: gynecological exam: _____ Pap Smear ___ Mammogram _____ Bone Scan _____

Include results: _____
 # of Days between periods: _____ # of days of flow: _____ Color of flow: _____

Average # of pads/tampons used per day: 1st day _____ 2nd day _____ 3rd day _____ 4th day _____ +days _____

Have you been diagnosed with: fibroids Fibrocystic Breasts Endometriosis Ovarian Cysts PID
 Other _____

Location of Pain: Lower abdomen Lower back Thighs Other _____

Nature of Pain: (please indicate before, during, or after menses) **Other Symptoms related to menses**

- | | | | | |
|------------------------------|--------------------|--|--|---|
| Cramping _____ | Stabbing _____ | <input type="checkbox"/> Discharge | <input type="checkbox"/> Vaginal dryness | <input type="checkbox"/> Headache |
| Burning _____ | Aching _____ | <input type="checkbox"/> Nausea | <input type="checkbox"/> Constipation | <input type="checkbox"/> Diarrhea |
| Dull _____ | Bloating _____ | <input type="checkbox"/> Swollen breasts | <input type="checkbox"/> Mood Swings | <input type="checkbox"/> Insomnia |
| Consistent _____ | Intermittent _____ | <input type="checkbox"/> Ravenous appetite | <input type="checkbox"/> Poor appetite | |
| Bearing down sensation _____ | | <input type="checkbox"/> Hot flashes | <input type="checkbox"/> Night sweats | <input type="checkbox"/> Increased libido |
| | | <input type="checkbox"/> Decreased libido | | |

FOR MEN

Date of last prostate check up _____ PSA results _____ Manual prostate exam results _____

Lab results _____

Frequency of Urination: daytime _____ nighttime _____ Color of urine: clear murky odor: _____

Symptoms related to prostate

- | | | | |
|--|---|---|---|
| <input type="checkbox"/> Prostate problems | <input type="checkbox"/> Delayed stream | <input type="checkbox"/> Dribbling | <input type="checkbox"/> Incontinence |
| <input type="checkbox"/> Retention of urine | <input type="checkbox"/> Rectal dysfunction | <input type="checkbox"/> Increased libido | <input type="checkbox"/> Decreased libido |
| <input type="checkbox"/> Premature ejaculation | <input type="checkbox"/> Impotence | <input type="checkbox"/> Back pain | <input type="checkbox"/> Groin pain |
| <input type="checkbox"/> Testicular pain | other _____ | | |

SYMPTOM SURVEY (For Everyone)

The following is a list of symptoms that you may or may not ever experience.

Please indicate as follows:

no mark = never experience **check mark (✓)** = sometimes experience **Plus sign (+)** = frequently experience

<input type="checkbox"/> lack of appetite <input type="checkbox"/> excessive appetite <input type="checkbox"/> loose stools or diarrhea <input type="checkbox"/> digestive problems, indigestion <input type="checkbox"/> vomiting <input type="checkbox"/> belching, burping <input type="checkbox"/> heartburn, reflux <input type="checkbox"/> feeling of retention of food in the stomach <input type="checkbox"/> tendency to become obsessive in work, relationships... <hr/> <input type="checkbox"/> insomnia, difficulty sleeping <input type="checkbox"/> heart palpitations <input type="checkbox"/> cold hands and feet <input type="checkbox"/> nightmares <input type="checkbox"/> mentally restless <input type="checkbox"/> laughing for no apparent reason <input type="checkbox"/> angina pains	<input type="checkbox"/> abdominal pain <input type="checkbox"/> chest pain <input type="checkbox"/> sciatic pain <input type="checkbox"/> headaches <input type="checkbox"/> pain or coldness in genital area <hr/> <input type="checkbox"/> cough <input type="checkbox"/> shortness of breath <input type="checkbox"/> decreased sense of smell <input type="checkbox"/> nasal problems <input type="checkbox"/> skin problems <input type="checkbox"/> feeling of claustrophobia <input type="checkbox"/> bronchitis <input type="checkbox"/> colitis or diverticulitis <input type="checkbox"/> constipation <input type="checkbox"/> hemorrhoids <input type="checkbox"/> recent use of antibiotics	<input type="checkbox"/> eye problems <input type="checkbox"/> jaundice (yellowish eyes or skin) <input type="checkbox"/> difficulty digesting oily foods <input type="checkbox"/> gall stones <input type="checkbox"/> light colored stool <input type="checkbox"/> soft or brittle nails <input type="checkbox"/> easily angered or agitated <input type="checkbox"/> difficulty in making plans or decisions <input type="checkbox"/> spasms or twitching <hr/> <input type="checkbox"/> low back pain <input type="checkbox"/> knee problems <input type="checkbox"/> hearing impairment <input type="checkbox"/> ear ringing <input type="checkbox"/> kidney stones <input type="checkbox"/> decreased sex drive <input type="checkbox"/> hair loss <input type="checkbox"/> urinary problems	<input type="checkbox"/> fatigue <input type="checkbox"/> edema <input type="checkbox"/> blood in stool <input type="checkbox"/> black tarry stool <input type="checkbox"/> easily bruised <input type="checkbox"/> difficult to stop bleeding <input type="checkbox"/> asthma <input type="checkbox"/> tendency to catch colds easily <input type="checkbox"/> intolerance to weather changes <input type="checkbox"/> allergies <input type="checkbox"/> hay fever <input type="checkbox"/> dizziness <input type="checkbox"/> tendency to faint easily <input type="checkbox"/> high cholesterol levels <input type="checkbox"/> sudden weight loss
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Please answer the following questions if you have PAIN:

describe location: _____

quality of pain:(circle) dull sharp stabbing sore cramping throbbing burning
 constant radiating fixed moves about severe moderate

pain radiates to: _____

describe the onset of the pain: _____

helps pain (circle): ice heat rest movement am p.m. dampness dry
 aggravates(circle): ice heat rest movement am p.m. dampness dry

Are there any movements that aggravate the pain (list) _____

How does exercise affect your pain _____

Do any medications help your pain _____

Other treatments you've had for the pain _____

