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 ____________________________ Cell ________________

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). ____
____
____

<u>Practitioner's Use Only</u>

□ Onset **□ Location** **□ Duration** **□ Characteristics**
□ Aggrevate/Allev **□ Related Factors** **□Treatment** **□ 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	□	□	□	□	□	________________
Family	□	□	□	□	□	________________
Diet	□	□	□	□	□	________________
Sex	□	□	□	□	□	________________
Self	□	□	□	□	□	________________
Work	□	□	□	□	□	________________
Exercise	□	□	□	□	□	________________
Spirituality	□	□	□	□	□	________________

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 day4th 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)
Cramping_____ Stabbing ________
Burning ______ Aching _____
Dull _________ Bloating ________
Consistent _________ Intermittent______
Bearing down sensation _______________

Other Symptoms related to menses
□Discharge □ Vaginal dryness □ Headache
□Nausea □ Constipation □ Diarrhea
□ Swollen breasts □ Mood Swings □ Insomnia
□ Ravenous appetite □ Poor appetite
□ Hot flashes □ Night sweats □ Increased libido
□ 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
□ Prostate problems □ Delayed stream □ Dribbling □ Incontinence
□ Retention of urine □ Rectal dysfunction □ Increased libido □ Decreased libido
□ Premature ejaculation □ Impotence □ Back pain □ Groin pain
□ 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

_____lack of appetite
_____excessive appetite
_____loose stools or diarrhea
_____digestive problems, indigestion
_____vomiting
_____belching, burping
_____heartburn, reflux
_____feeling of retention of food in the stomach
_____tendency to become obsessive in work, relationships…

_____insomnia, difficulty sleeping
_____heart palpitations
_____cold hands and feet
_____nightmares
_____mentally restless
_____laughing for no apparent reason
_____angina pains

_____abdominal pain
_____chest pain
_____sciatic pain
_____headaches
_____pain or coldness in genital area

_____cough
_____shortness of breath
_____decreased sense of smell
_____nasal problems
_____skin problems
_____feeling of claustrophobia
_____bronchitis
_____colitis or diverticulitis
_____constipation
_____hemorrhoids
_____recent use of antibiotics

_____eye problems
_____jaundice (yellowish eyes or skin)
_____difficulty digesting oily foods
_____gall stones
_____light colored stool
_____soft or brittle nails
_____easily angered or agitated
_____difficulty in making plans or decisions
_____spasms or twitching

_____low back pain
_____knee problems
_____hearing impairment
_____ear ringing
_____kidney stones
_____decreased sex drive
_____hair loss
_____urinary problems

_____fatigue
_____edema
_____blood in stool
_____black tarry stool
_____easily bruised
_____difficult to stop bleeding
_____asthma
_____tendency to catch colds easily
_____intolerance to weather changes
_____allergies
_____hay fever
_____dizziness
_____tendency to faint easily
_____high cholesterol levels
_____sudden weight loss

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____