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Licensed Acupuncturist

Health History Questionnaire

Please take the time to complete this form thoroughly and thoughtfully. The answers you provide will help me to understand your health concerns in order to formulate a treatment plan that works for you. If you cannot remember specific details, best estimates are fine. All of the information you provide on this form is absolutely confidential. If you have any questions, please ask. Thank you!

Name:_____ Date:_____

Address:_____

City:_____ State:_____ Zip Code:_____

Home Telephone:_____ Work Telephone:_____

Cellular Telephone:_____ Email:_____

Date of Birth:_____ Marital Status:_____

Occupation:_____ Referred By:_____

General Physician:_____ Telephone:_____

Address_____

City:_____ State:_____ Zip Code:_____

In Case of Emergency Notify:_____ Telephone:_____

Main complaint (symptoms, diagnosis, & duration)

_____

_____

_____

_____

_____

_____

Significant illness or trauma (physical or emotional)

_____

Surgeries (please include date and type of procedure)

_____

Allergies (drugs, chemicals, foods)

_____

Medications (type & dosage)

_____

Vitamins, herbs, homeopathic remedies, supplements (type & dosage)

_____

Occupational Stress (chemical, physical, psychological, etc.)

_____

Do you exercise? If so, please note how many days per week, type of exercise, and length of work out.

_____

Please describe your diet on a typical day:

Morning:_____Afternoon:_____Evening:_____

How much alcohol do you drink each week?_____ Caffeinated drinks?_____

Do you smoke?_____ If yes, how much do you smoke per day?_____

Do you use any medications/drugs for non-medicinal purposes?_____

Family Medical History:

Please indicate whether any of the conditions listed below apply to your immediate family. Put an M (mother), F (father), S (sister), B (brother), GM (grandmother), GF (grandfather).

Diabetes___	Seizures___	Heart Disease___	Stroke___
Allergies___	Cancer___	Asthma___	High Blood Pressure___
Other_____			

Personal Medical History:

Please indicate whether you are currently experiencing any of the symptoms or conditions listed below:

Arthritis	Liver/Gallbladder Disease	Stroke	Heart Disease
Ulcer	Hypo/Hyperglycemia	Kidney Disease	Diabetes
Cancer	High Cholesterol	Food Allergies	Seizures
Hepatitis	High/Low Blood Pressure	Diverticulitis/IBS	Raynaud's Disease
Infertility	Chronic Fatigue	Thyroid Imbalance	Lyme Disease
Anemia	Respiratory Allergies	Alcoholism	Impotence
Asthma	Gastritis/Pancreatitis	Emphysema	

Please check if you have experienced any of the symptoms or conditions listed below in the last **year.** Put a star next to any of the symptoms if you've experienced them in the past but do not any longer.

General

Spontaneous Sweating	Poor appetite	Poor Sleep	Fatigue	Localized Weakness
Change in Appetite	Night Sweats	Dizziness	Cravings	Change in Energy
Bleed/Bruise Easily	Strong thirst	Fevers	Chills	Muscle Weakness
Weight Loss/Gain	Dental Problems	Tremors		

Skin & Hair

Skin Discoloration	Rashes	Dermatitis	Ulcerations	Hives
Fungal Infection	Itching	Eczema	Psoriasis	Recent Moles
Athlete's Foot	Acne	Warts	Dandruff	Loss of Hair
Facial Flushing	Dry Hair	Weak or ridged nails		

Head, Eyes, Ears, Nose & Throat

Headaches	Migraines	Dizziness	Eye Strain
Eye Pain	Spots in Front of Eyes	Change in Vision	Poor Vision
Night Blindness	Blurred Vision	Color Blindness	Itchy, Red Eyes
Ringing in Ears	Earaches	Loss of Hearing	Sinus Problems
Nose Bleeds	Post-Nasal Drip	Recurrent sore throats/colds	
Grinding Teeth	Dental Problems	Mouth/Lip Sores	
Jaw Clicks/Locks	Bleeding Gums		

Cardiovascular

Chest Tightness or Pain	Heart Palpitations	Irregular Heart Beat
Cold Hands/Feet	Swelling of Hands/Feet	Fainting
Phlebitis	Blood Clots	Shortness of Breath
Spider/Varicose Veins	High Blood Pressure	Low Blood Pressure
Spontaneous Sweating		

Respiratory

Chronic Cough	Coughing Blood	Asthma	Bronchitis
Pain upon Inhalation	Pneumonia	Difficulty Inhaling/Exhaling	

Production of Phlegm (what color?_____)

Gastrointestinal

Abdominal Pain	Poor Appetite	Nausea	Vomiting
Diarrhea	Constipation	Gas	Bloating
Belching	Blood in Stools	Hemorrhoids	Black Stools
Indigestion	Bad Breath	Rectal Pain	Edema
Chronic Laxative Use	Acid Reflux/GERD	Hernia	IBS
Crohn's Disease	Excessive Appetite	Excessive Thirst	Ulcers

Genito-Urinary

Pain with Urination	Frequent Urination	Blood in Urine	Urgent Urination
Incontinence	Scanty Flow	Copious Flow	Burning Urination
Urinary Tract Infection	Genital Sores	Kidney Stones	Impotence
Nocturnal Emission	Decreased Libido	Pain in Testicles	Herpes
Infections	Dribbling After Urination		Prostatitis

Night Urination (How many times per night?____ What time?_____)

Gynecological/Reproductive

Age of first menses_____ Date of last menses_____ Date of last PAP/Pelvic_____
# of Pregnancies_____ # of Ectopic Pregnancies_____ # of Live Births_____
# of Miscarriages_____ # of Abortions_____ Do you practice birth control? _____
What type?_____ For how long?_____

Painful Intercourse	Vulvadynia	Ovarian Cysts	Endometriosis
Uterine Fibroids	Vaginal Dryness	Vaginal Discharge	Infertility
Irregular Menstruation	PMS	Painful Menstruation	Fibrocystic Breasts
Polycystic Ovarian Disease	Heavy Bleeding		Mid-cycle bleeding

Musculoskeletal

Hand/Wrist pain	Carpal Tunnel	Thoracic Outlet Syndrome	Elbow pain
Shoulder pain	Neck pain	Knee pain Foot/Ankle pain	Hip pain
Tendonitis	Sprains/Strains	Muscle Weakness	Bursitis
Muscle pain	Rotator cuff	Back pain: low___ middle____upper____	

Neurological

Seizures	Loss of Balance	Vertigo/Dizziness
Areas of numbness	Poor Memory	Concussion
Depression	Lack of Coordination	Nervousness
Anxiety/Panic Attacks	Seasonal Affective Disorder	ADD/ADHD
Manic Depression		

Emotional

Insomnia	Irritability	Often feel angry	Troubling dreams
Cry uncontrollably	Feel sad a lot	Forgetful	Mind not clear
Anxiety/Panic Attacks	Unrestrained joy	Much fear	Terrors
Depression	Manic Depression	Nervousness	
Seasonal Affective Disorder		Difficulty expressing emotions	

Have you ever been treated for substance abuse?_____
Have you ever considered or attempted suicide?_____

Please use the space provided below to inform me of any other health problems you would like to address.

_____

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