



## Health History Questionnaire

Please help us provide you with a complete evaluation by taking the time to fill out this questionnaire carefully. All of your answers will be held absolutely confidential. If you have questions, please ask. If there is anything you wish to bring to our attention, which is not asked on this form, please note it in the "comments" section. Thank you.

Name \_\_\_\_\_ Date \_\_\_\_\_

Street \_\_\_\_\_ City \_\_\_\_\_ State/Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Email \_\_\_\_\_

Age \_\_\_\_\_ Date of Birth \_\_\_\_\_ Male \_\_\_\_\_ Female \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_

Marital Status       Married       Never Married       Widowed       Divorced

Education             Grammar School       High School             College             Masters

Occupation \_\_\_\_\_ Retired \_\_\_\_\_ Disabled \_\_\_\_\_ Unemployed \_\_\_\_\_

Family Physician \_\_\_\_\_ Referred by \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Emergency contact phone number \_\_\_\_\_

Have you ever been treated with acupuncture or Oriental medicine before?

Main problem you would like us to help you with \_\_\_\_\_

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When did the problem begin? Please be specific \_\_\_\_\_

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Have you been given a diagnosis for this problem? If so, what diagnosis and by whom?

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What other kinds of treatment have you tried?       Western Medicine       Acupuncture

Herbs             Massage       Physical Therapy       Chiropractor             Reiki

Homeopathy       Other \_\_\_\_\_

Secondary complaints you would like us to address\_\_\_\_\_

Past personal medical history      Asthma      Allergies      Diabetes  
 Cancer      Stroke      Heart Disease      High Blood Pressure  
 Seizures      Hepatitis      Rheumatic Fever      Thyroid Disease  
 Venereal Disease      Other:\_\_\_\_\_

Hospitalizations/Surgeries (include dates)\_\_\_\_\_

Significant Trauma (auto accidents, falls, etc)\_\_\_\_\_

Allergies (drugs, chemicals, metals, foods)\_\_\_\_\_

Medications taken within the last two months (vitamins, drugs, herbs, etc)\_\_\_\_\_

Are there any areas of your life that you find stressful? Please describe:\_\_\_\_\_

Do you have a regular exercise program?      No      Yes  
If yes, please describe\_\_\_\_\_

Do you follow any type of special diet?      No      Yes  
If yes, please describe\_\_\_\_\_

Describe your average daily diet:  
Morning\_\_\_\_\_

Afternoon\_\_\_\_\_

Evening\_\_\_\_\_

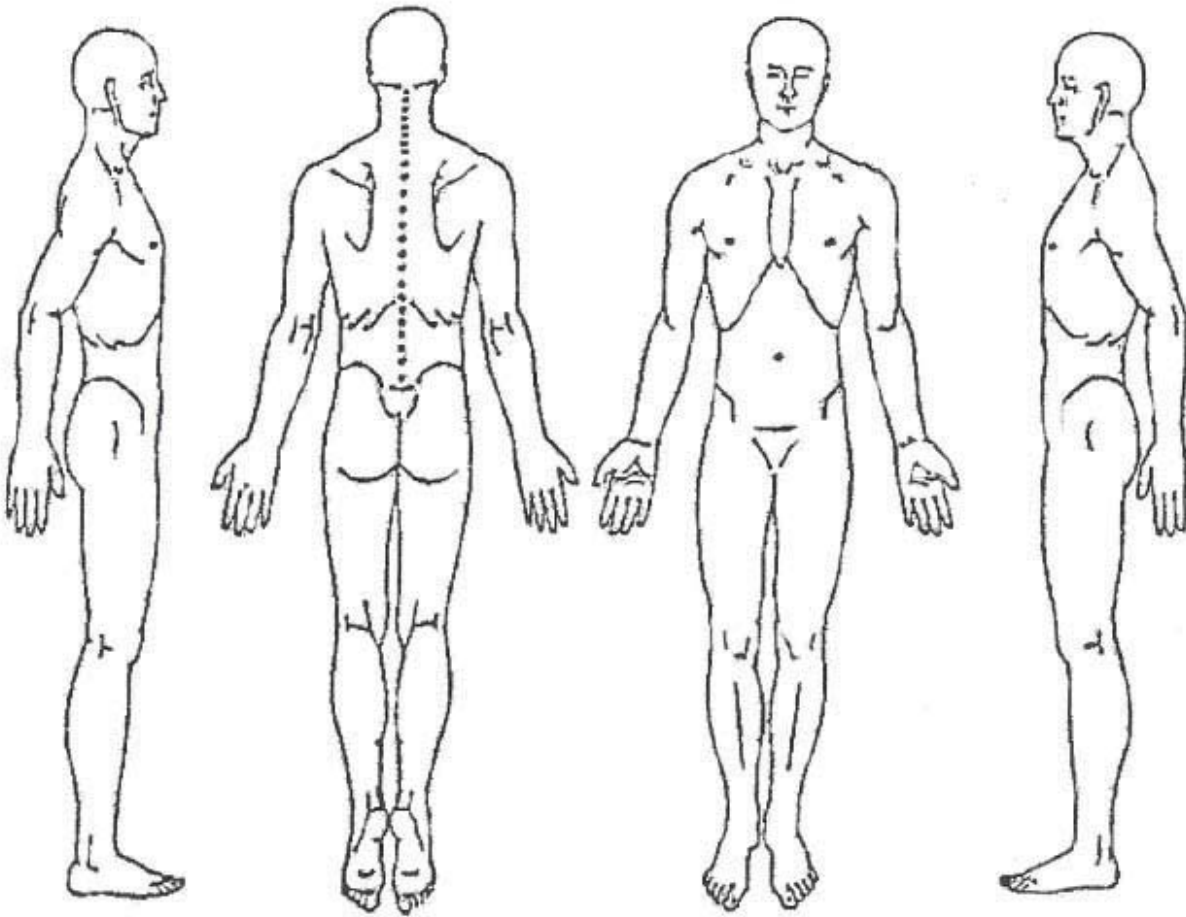
Do you smoke?       No      Yes If yes, what and how much?\_\_\_\_\_

How many cups of caffeinated coffee, tea, or cola do you drink per day/week?\_\_\_\_\_

How many 8 oz. glasses of water do you drink per day/week?\_\_\_\_\_

How many alcoholic beverages do you drink per day/week?\_\_\_\_\_

Please indicate any painful or distressed body areas by circling the particular area:



Please check if you have had any of the following, particularly if in the last three months:

**GENERAL:**

- Fevers       Chills       Fatigue       Sweat easily       Poor sleeping
- Night sweats       Weight loss       Cravings       Weight gain
- Strong thirst for       hot drinks       cold drinks
- Sudden energy drop: time of day \_\_\_\_\_
- Bleed or bruise easily       Peculiar tastes or smells

**SKIN & HAIR:**

- Rashes       Ulcerations       Hives       Itching       Eczema       Pimples
- Dandruff       Loss of hair       Recent moles       Psoriasis       Dermatitis
- Acne       Change in hair or skin texture
- Any other skin or hair problems? \_\_\_\_\_

**HEAD, EYES, EARS, NOSE & THROAT:**

- Dizziness    Concussions    Migraines    Glasses    Eye strain  
 Eye pain    Poor vision    Night blindness    Color blindness  
 Cataracts    Blurry vision    Earaches    Ringing in ears  
 Poor hearing    Sinus problems    Nose bleeds    Recurrent sore throats  
 Grinding teeth    Clenching jaw    Facial pain    Sores on lips or tongue  
 Teeth problems    Jaw clicks  
 Headaches, where and when? \_\_\_\_\_  
 Any other head or neck problems? \_\_\_\_\_

**CARDIOVASCULAR:**

- High blood pressure    Low blood pressure    Chest pain    Fainting  
 Irregular heart beat    Difficulty in breathing    Blood clots    Phlebitis  
 Cold hands or feet    Swelling of hands    Swelling of feet  
 Varicose or spider veins    Palpitations    Palpitations at rest  
 Any other heart or blood vessel problems? \_\_\_\_\_

**RESPIRATORY:**

- Cough    Coughing blood    Asthma    Bronchitis  
 Pneumonia    Pain with deep breath    Chest tightness  
 Difficulty breathing when lying down  
 Phlegm production, what color? \_\_\_\_\_

**GASTROINTESTINAL:**

- Nausea    Vomiting    Diarrhea    Constipation  
 Gas    Belching    Black stools    Blood in stools  
 Indigestion    Bad breath    Rectal pain    Hemorrhoids  
 Bleeding gums    Food stagnation    Bloating/edema    Acid reflux/GERD  
 Hernia    Excessive appetite    Poor appetite    IBS/Crohn's disease  
 Colitis    Slow digestion    Abdominal pain/cramps  
 Chronic laxative use    Loose stools, more than 2 per day  
 Any other problem with Stomach or intestines \_\_\_\_\_

**GENITO-URINARY:**

- Frequent urination    Blood in urine    Pain upon urination  
 Urgency to urinate    Unable to hold urine    Kidney stones  
 Decrease in flow    Impotency    Sores on genitals  
 Any particular color to your urine? \_\_\_\_\_  
 Do you wake up at night to urinate? If yes, how many times a night? \_\_\_\_\_  
 Any other problems with your genital or urinary systems? \_\_\_\_\_

**REPRODUCTIVE & GYNECOLOGIC:**

Are you pregnant?  Yes  No

Is it possible that you are pregnant?  Yes  No

Number of pregnancies: \_\_\_\_\_ Live Births: \_\_\_\_\_ Miscarriages: \_\_\_\_\_

Abortions: \_\_\_\_\_ Premature births: \_\_\_\_\_

Age at first menses: \_\_\_\_\_ Time period between menses: \_\_\_\_\_

Duration of menses: \_\_\_\_\_ Last PAP: \_\_\_\_\_

- Irregular periods     Painful periods     Clots     Breast lumps
- Vaginal sores         Vaginal discharge  Vaginal dryness Endometriosis
- Uterine fibroids     Polycystic Ovarian disease     Fibrocystic breast tissue
- Unusual character of blood (heavy, scanty) \_\_\_\_\_

Do you practice birth control?  Yes  No If yes, what type? \_\_\_\_\_ How long? \_\_\_\_\_

**MUSCULOSKELETAL:**

- Neck pain                     Rotator cuff     Knee pain                     Foot/ankle pain
- Muscle pain                 Muscle spasm  Muscle weakness     Shoulder pain
- Hip pain                     Sciatica         Bursitis                     Hand/wrist pain
- Carpal tunnel             Sprains/strains  Tendonitis
- Back pain: Low \_\_\_\_\_ Middle \_\_\_\_\_ Upper \_\_\_\_\_
- Soreness/weakness of lower body (back, hip, knee, ankle, foot)

**NEUROLOGICAL & PSYCHOLOGICAL:**

- Seizures                     Dizziness         Loss of balance     Areas of numbness
- Poor memory             Concussion     Poor coordination     Bad temper
- Anxiety                     Depression     Easily susceptible to stress
- Nervousness             ADD/ADHD     Manic depression

Have you ever been treated for emotional problems?  Yes  No

Have you ever considered or attempted suicide?  Yes  No

Any other neurological or psychological problems? \_\_\_\_\_

**COMMENTS:** Please tell us briefly of any other problems you would like to discuss.

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