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HEALTH HISTORY QUESTIONNAIRE

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

Today's Date: _____
Name: _____**Email:**_____
Address: _____**City:**_____**Zip:**_____
Home: (_____) _____ **Work:** (_____) _____ **ext.** _____ **Cell/other:** (_____) _____
Age: _____ **Date of Birth:** _____**Referred by:**_____
Emergency Contact: _____
Have you been treated with acupuncture or Oriental medicine before? ___ Yes ___ No
Main problem(s) you would like us to help you with: _____
_____
When did this condition begin? (Be as specific as possible.) _____
To what extent does this problem interfere with your daily activities? _____
_____
Have you been given a diagnosis for this problem? If so, what? _____
What kind of treatment have you tried, and with what result? _____
_____
_____

(Please indicate dates in space provided, if it applies):
___ Cancer (_____) ___ Diabetes (_____) ___ Hepatitis (_____)
___ Heart disease (_____) ___ Seizures (_____) ___ High blood pressure (_____)
___ Venereal disease (_____)
___ Other (please describe): _____
Surgical procedures: _____
_____
_____
Significant traumas (auto accident, fall, etc.): _____
_____
_____
Unusual conditions present during your birth (prolonged labor, forceps delivery, etc.): _____
_____
Allergies (drugs, chemicals, foods, etc.): _____
_____
Has anyone in your family suffered from:
___ Diabetes ___ Cancer ___ High blood pressure
___ Heart disease ___ Stroke ___ Seizures
___ Asthma ___ Allergies
___ Other (please describe): _____

Medicines taken within the last two months (vitamins, drugs, herbs, etc.): _____

_____

Occupation: _____

Occupational stress (physical, psychological, chemical, etc.): _____

Do you have a regular exercise program? ___ Yes ___ No Please describe: _____

_____

Have you been on a restricted diet? ___ Yes ___ No Please describe: _____

Do you smoke? ___ Yes ___ No If so, how often and how much? _____

How many caffeinated beverages do you drink per day or week? _____

Please check if, *in the last three months*, you have experienced the following: (or frequently)

GENERAL

___ Poor appetite ___ Poor sleeping ___ Fatigue
___ Fevers ___ Chills ___ Night sweats
___ Sweat easily ___ Tremors ___ Cravings
___ Localized weakness ___ Poor balance ___ Change in appetite
___ Bleed or bruise easily ___ Weight loss ___ Weight gain
___ Peculiar tastes or smells ___ Strong thirst (cold or hot drinks)
___ Sudden energy drop (During what time of day?_____)

SKIN AND HAIR

___ Rashes ___ Ulcerations ___ Hives
___ Itching ___ Eczema ___ Pimples
___ Dandruff ___ Loss of hair ___ Recent moles
___ Change in hair/skin texture
___ Other (please describe): _____

HEAD, EYES, EARS, NOSE, AND THROAT

___ Dizziness ___ Concussions ___ Migraines
___ Glasses/contact lenses ___ Eye strain ___ Eye pain
___ Poor vision ___ Night blindness ___ Color blindness
___ Cataracts ___ Blurry vision ___ Earaches
___ Ringing in ears ___ Poor hearing ___ Spots in front of eyes
___ Sinus problem ___ Nose bleeds ___ Recurrent sore throats
___ Grinding teeth ___ Facial pain ___ Sores on lips or tongue
___ Teeth problem ___ Jaw clicks
___ Headaches (What part of the head, and when?) _____
___ Other (please describe): _____

CARDIOVASCULAR

___ High blood pressure ___ Low blood pressure ___ Chest pain
___ Irregular heartbeat ___ Dizziness ___ Fainting
___ Cold hands or feet ___ Swelling of hands ___ Swelling of feet
___ Blood clots ___ Phlebitis ___ Difficulty in breathing
___ Other (please describe): _____

RESPIRATORY

___ Cough ___ Coughing up blood ___ Asthma
___ Bronchitis ___ Pneumonia ___ Pain with a deep breathing
___ Other (please describe): _____

GASTROINTESTINAL

___ Nausea ___ Vomiting ___ Diarrhea
___ Constipation ___ Gas ___ Belching
___ Black stools ___ Blood in stools ___ Indigestion
___ Bad breath ___ Rectal pain ___ Hemorrhoids
___ Abdominal pain or cramps ___ Chronic laxative use
___ Other (please describe): _____

GENITO-URINARY

___ Painful urination ___ Frequent urination ___ Blood in urine
___ Urgency to urinate ___ Unable to hold urine ___ Kidney stones
___ Decrease in flow ___ Impotence ___ Sores on genitals
___ Other (please describe): _____
Do you wake up at night to urinate? ___ Yes ___ No How often? _____
Any particular color to your urine? ___ Yes ___ No Please describe: _____

GYNECOLOGYAND PREGNANCY

___ Irregular periods ___ Painful periods ___ Clots
___ Vaginal discharge ___ Vaginal sores ___ Breast lumps
___ Unusual character of period ___ Change in body/emotions prior to period (heavy or light)
___ Other (please describe): _____
First date of last menstrual period: _____ **Duration:** _____
Number of days between menstrual periods: _____
Number of pregnancies: _____ **Number of births:** _____ **Number of premature births:** _____
Number of miscarriages: _____ **Number of abortions:** _____
Do you practice birth control? ___ Yes ___ No
What method, and for how long? _____

NEUROPSYCHOLOGICAL

___ Seizures ___ Dizziness ___ Loss of balance
___ Areas of numbness ___ Lack of coordination ___ Poor memory
___ Depression ___ Anxiety___ Bad temper ___ Easily susceptible to stress
___ Other (please describe): _____
Have you been treated for emotional problem? ___ Yes ___ No

COMMENTS

Please describe any other problems you would like to discuss: _____
_____