PARTNERS IN HEALING

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HEALTH HISTORY QUESTIONNAIRE
Information for your Acupuncturist

Important: Complete this document as thoroughly as possible. Some of the questions that follow may seem unrelated to your condition, but they may play a major role in diagnosis and treatment.
All information is strictly confidential.

I. General Patient Information

Date: ____/____/____

Name: _____

Address: _____

City, State, Postal Code: _____

Cell Phone: _(_____)_____ Cell Phone Carrier: _____
Home Phone: _(____)_____

Emergency contact name_____ Phone Number _____

Email address_____

Age: _____ Date of Birth: ____/____/____ Place of Birth: _____

Guardian (if under 18): _____

Gender: ' M ' F Height: ____'____" Weight: _____lbs.

Marital Status: *single, married, widowed, divorced, partner*

Occupation:_____Employer:_____

How did you hear about our office? _____

Chief complaint _____
How long have you had this problem? _____
Did any illness or incident precede this problem? _____
Have you been given a diagnosis by your physician? Yes • No •
If so, what is it? _____
What type of treatment/therapy have you tried? _____
_____
Did you get any relief? Yes • No •

Major Complaint(s), in order of significance to you:

	Severe	Moderate	Slight	Normal
1. _____	‘	‘	‘	‘
2. _____	‘	‘	‘	‘
3. _____	‘	‘	‘	‘
4. _____	‘	‘	‘	‘
5. _____	‘	‘	‘	‘

How do these conditions impair your daily activities?_____

II. Patient Medical History

How was your childhood health?_____

Hospital Visits/Stays:_____

Major Traumas_____

Surgeries_____

Prescription Medications_____

Drug allergies/intolerances_____

Over the counter medications_____

Vitamins and Supplements_____

Recent tests: (please indicate test results and date below)

‘ Physical	‘ Cholesterol	‘ Prostate	‘ Blood (which?)
‘ HIV/STD	‘ Pap smear	‘ Mammography	‘ Other:_____

Test Results and Date:_____

Check any you have had in the past:

‘ Diabetes	‘ Allergies	‘ Glaucoma	‘ Rheumatic Fever
‘ Heart Disease	‘ CVA (stroke)	‘ Vein condition	‘ Thyroid disorder
‘ Asthma	‘ Pneumonia	‘ Tuberculosis	‘ Emphysema
‘ Jaundice	‘ Gonorrhea	‘ Mumps	‘ Bleeding tendency
‘ Syphilis	‘ Measles	‘ Chicken pox	‘ Nervous disorder
‘ Meningitis	‘ HIV	‘ Polio	‘ Mononucleosis
‘ Epilepsy	‘ High fever	‘ Hepatitis	‘ Multiple Sclerosis
‘ Paralysis	‘ Cancer	‘ Migraines	‘ High blood pressure
‘ other lung illnesses	‘ other liver illnesses	‘ other heart illnesses	‘ other kidney illnesses
‘ other:_____			

Immunizations:_____

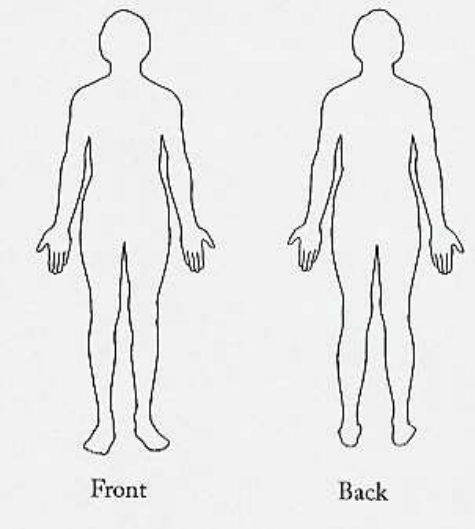
Surgeries:_____

Check the following that have occurred in your blood relatives:

‘ Diabetes ‘ Cancer ‘ Heart Disease ‘ High Blood Pressure
‘ Allergies ‘ Tuberculosis ‘ Obesity ‘ Bleeding Tendency
‘ Kidney disease ‘ Alcoholism ‘ Nervous Illness ‘ Mental Illness
‘ Stroke ‘ Other_____

III. Patient Profile

Please clearly mark any areas of pain and any scars (please indicate which of the areas are scars with the letter ‘S’):



Is the pain:
‘ Sharp ‘ Burning ‘ Aching
‘ Cramping ‘ Dull ‘ Moving
‘ Fixed Other:_____

Do the following lessen the pain?
‘ Pressure ‘ Cold ‘ Heat
‘ Exercise ‘ Other:_____

Do the following worsen the pain?
‘ Pressure ‘ Cold ‘ Heat
‘ Other:_____

Please check the following that currently pertain to you

<u>Overall Temperature (Kidney function)</u>:
‘ Cold hands
‘ Cold fingers
‘ Cold feet
‘ Cold toes
‘ Sweaty hands
‘ Sweaty feet
‘ Hot body temperature (sensation)
‘ Cold body temperature (sensation)
‘ Afternoon flushes

‘ Night sweats
‘ Heat in the hands, feet, and chest
‘ Hot flashes any time of the day
‘ Thirsty
‘ Perspire easily
‘ Lack of perspiration
‘ Take water to bed

Overall energy (Lung, Kidney function):
‘ Shortness of breath
‘ Difficulty keeping eyes open in the daytime
‘ General weakness
‘ Easily catch colds
‘ Low energy
‘ Feel worse after exercise

Overall blood (Liver, Spleen, Heart function):
‘ Dizziness
‘ See floating black spots

Heart function:
‘ Palpitations
‘ Anxiety
‘ Sores on the tip of the tongue
‘ Restlessness
‘ Mental confusion
‘ Chest pain traveling to shoulder
‘ Frequent dreams
‘ Wake unrefreshed
‘ Drink coffee (# of cups per week: _____)

Lung function:
‘ Nasal Discharge (Color: _____)
‘ Cough
‘ Nose Bleeds
‘ Sinus Congestion
‘ Dry mouth
‘ Dry throat
‘ Headache (Location: _____)
‘ Dry Nose
‘ Dry Skin
‘ Allergies (To what? _____)
‘ Alternating fever and chills
‘ Smoke cigarettes (# of cigarettes per day: _____)
‘ Overall achy feeling of the body
‘ Stiff neck
‘ Stiff shoulders
‘ Sore throat
‘ Difficulty breathing
‘ Sneezing
‘ Sadness
‘ Melancholy

Spleen function:
‘ Low appetite
‘ Abrupt weight gain
‘ Abrupt weight loss
‘ Abdominal bloating
‘ Abdominal gas
‘ Gurgling noise in the stomach
‘ Fatigue after eating
‘ Prolapsed organs (previously diagnosed, which organ? _____)
‘ Pensive
‘ Over-thinking
‘ Worry

Spleen, Stomach, Large Intestine, Small Intestine function:

‘ Loose
‘ Constipated
‘ Incomplete
‘ Diarrhea
‘ Blood in stools
‘ Mucous in stools
‘ Undigested food in stools

Dampness trapped in the body:

‘ General sensation of heaviness in the body
‘ Mental heaviness
‘ Mental sluggishness
‘ Mental fogginess
‘ Swollen hands
‘ Swollen feet
‘ Swollen joints
‘ Chest congestion
‘ Nausea
‘ Snoring

Stomach function:

‘ Burning sensation after eating
‘ Large appetite
‘ Bad breath
‘ Mouth (canker) sores
‘ Bleeding, swollen or painful gums
‘ Heartburn
‘ Acid regurgitation
‘ Ulcer (diagnosed)
‘ Belching
‘ Hiccoughs
‘ Stomach pain
‘ Vomiting

Eyes (Liver function):

‘ Itchy
‘ Bloodshot
‘ Hot
‘ Dry
‘ Watery
‘ Gritty
‘ Blurry vision
‘ Decreased night vision
‘ Near-sighted
‘ Far-sighted

Kidney, Urinary Bladder function:

‘ Frequent cavities
‘ Easily broken bones
‘ Sore knees
‘ Weak knees
‘ Cold sensation in the knees
‘ Low back pain
‘ Memory problems
‘ Excessive hair loss
‘ Low-pitched ringing in the ears

Liver, Gall Bladder function:

‘ Alternating diarrhea and constipation
‘ Chest pain
‘ Tight sensation in the chest
‘ Bitter taste in the mouth
‘ Anger easily
‘ Frustration
‘ Depression
‘ Irritability
‘ Frequently unable to adapt to stress
(What causes the stress? _____)
‘ Skin rashes
‘ Headache at the top of the head
‘ Tingling sensation
‘ Numbness
‘ Muscle spasms
‘ Muscle twitching
‘ Muscle cramping
‘ Seizures
‘ Convulsions
‘ Lump in the throat
‘ Neck tension

‘ Kidney stones
‘ Bladder infections
‘ Wake during the night twice or more to urinate
‘ Lack of bladder control
‘ Fear
‘ Easily startled

‘ Limited Range-of-Motion, Neck
‘ Shoulder tension
‘ Limited Range-of-Motion, Shoulder
‘ Drink alcohol
‘ Recreational drugs
‘ High-pitched ringing in the ears
‘ Gall stones (history or current)

Urination: ‘ Normal color ‘ Dark yellow ‘ Clear ‘ Reddish ‘ Cloudy
‘ Scanty ‘ Profuse ‘ Strong odor ‘ Burning ‘ Painful
‘ Discharge ‘ Difficult ‘ Painful ‘ Urgent ‘ Frequent

Libido: ‘ Normal ‘ High ‘ Low

***Women only*:**
Method of Birth Control_____
Regular menstrual cycle? ‘ Y ‘ N Pregnant? ‘ Y ‘ N
Number of children:_____ Number of pregnancies:_____
Age of first menstruation:_____ Age of menopause (if applicable):_____
Average number of days of flow:_____ Average number of days of entire cycle:_____
❑Vaginal discharge ❑Bleeding between periods

Do you experience any of the following pre-menstrual syndromes?

‘ nausea ‘ vomiting ‘ water retention ‘ breast swelling
‘ food cravings ‘ headaches ‘ migraines ‘ breast tenderness
‘ depression ‘ irritability ‘ anxiety
‘ other emotions:_____
‘ dull pain, where?_____ ‘ sharp pain, where?_____

Please fill in the following menstrual chart:

	Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7
Color (normal, bright red, pale, brown, rust, dark, purple, other)							
Amount of flow (normal, heavy, light)							
Pain/cramps (location, dull, sharp, other)							
Clots (large, small, black, purple, red, other)							
Vomiting (check if yes)							
Nausea (check if yes)							
Other							

Men only:

‘ Swollen testes ‘ Testicular pain ‘ Impotence ‘ Premature ejaculation
‘ Feeling of coldness or numbness in external genitalia ‘ Other_____

Patient Signature:_____ Date_____

Acupuncturist Signature:_____

I have read and understand the HIPAA Notice of Privacy provided upon request.

Patient Signature:_____ Date_____