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Acupuncture and Chinese Medicine
Health History Questionnaire

Please help us provide you with a complete evaluation by taking the time to fill out this form. All of your answers will be held absolutely confidential. If you have any questions, please ask us.

Date: _____

Name: _____	Birthplace: _____
Address: _____	Date of Birth: _____
Home Phone: _____	Age: _____
Work Phone: _____	Cell Phone: _____
Emergency Contact: _____	Phone: _____
Primary Care Provider: _____	Referred by: _____
Occupation: _____	Height: _____ Weight: _____
Relationship Status: <input type="radio"/> Single <input type="radio"/> Married or Partnered <input type="radio"/> Divorced <input type="radio"/> Widowed	
Have you ever been treated with acupuncture or Chinese medicine before?	<input type="radio"/> Yes <input type="radio"/> No
Do you take an anti-coagulant medication (i.e. a blood-thinning drug) or Lithium?	<input type="radio"/> Yes <input type="radio"/> No
Do you take any drugs or supplements or have any medical condition that may contraindicate Chinese herbal therapies?	<input type="radio"/> Yes <input type="radio"/> No
Do you have an electronic implant like a pacemaker, or do you have any other condition that may contraindicate electro-stimulation treatment?	<input type="radio"/> Yes <input type="radio"/> No

<p>What is your main complaint for this visit?</p>	
<p>When did this problem begin?</p>	<p>Does it interfere with daily activities? <input type="radio"/> Yes <input type="radio"/> No</p>
<p>What improves and what aggravates your main complaint?</p>	
<p>Describe any previous diagnosis or treatments you have received for this complaint.</p>	

Please list all current and occasional drugs and supplements.

Current drugs and supplements:

Occasional drugs and supplements:

Please list all drug allergies:

Please list all other allergies (foods, animal dander, etc.):

Please list all significant surgeries and dental work:

Please list all major injuries and accidents (including birth trauma):

Please describe any current or historical mental or emotional disorders or predominant emotions:

How physically active are you each day? Include exercise and all other activity.

Inactive Slightly Active Moderately active Very Active Extremely Active

Diet

How many times a day do you eat?

Please describe your typical menus for each meal

Morning

Afternoon

Evening

Between Meals

Please indicate your weekly use, if any, of the following:

Sodas or other canned beverages

Coffee

Cigarettes

Recreational Drugs

Please check any historically significant or recent symptoms.

General

- Aversion to cold (not improved with warmth)
- Fear of Cold (improved with warmth)
- Chilliness of specific areas of the body
- Fever
- Morning hot flashes
- Afternoon hot flashes
- Hot hands and feet
- Fever and chills
- Alternating fever and chills
- Frequent sweating
- Night sweating
- Profuse sweating
- Scant sweating
- Sweating of specific areas of the body
- Generalized pain
- Heavy, tired body
- Paralysis or numbness
- Tremors or twitching
- Generalized itching
- Jaundice
- Edema
- Unusual weight gain or loss
- Fatigue
- Drowsiness after eating
- Afternoon fatigue
- Bleeding (bruising or hemorrhaging)
- Loss of consciousness
- Skin diseases

Head and Body

- Headache
- Migraines
- Heavy head sensation
- Unusual sensations in the head

- Dizziness or vertigo
- Dizziness with standing
- Fine, thin hair
- Excessive hair loss
- Premature graying
- Hot flashes in the head
- Facial pain
- Facial numbness or tic
- Facial swelling
- Deviated mouth and eyes
- Shoulder pain
- Frozen shoulder
- Arm pain
- Upper back pain
- Spinal column pain
- Lower back pain
- Tailbone pain
- Pain of the four limbs
- Numbness of the limbs
- Weak limbs
- Cold limbs
- Cold hands and feet
- Joint pain
- Inhibited stretching
- Inability to turn neck
- Stiff neck
- Neck pain
- Finger pain
- Finger numbness
- Hand tremors
- Pale, discolored, thick or deformed fingernails
- Knee pain and swelling
- Edema of the lower limbs
- Inflammation of the lower limbs
- Varicosities of the lower limbs
- Foot pain
- Foot or leg tremors

Urogenital

- Erectile dysfunction
- Premature ejaculation
- Inability to ejaculate
- Pain, itching, or discomfort of the penis or testicles
- Pain with urination
- Profuse urination
- Frequent urination
- Frequent urination at night
- Dribbling urination
- Bedwetting
- Incontinence
- Lack of urination or difficult urination
- Bloody urine
- Cloudy urine
- Soft, loose stools
- Diarrhea
- Dysentery
- Constipation
- Bloody stools
- Anal itching
- Rectal prolapse
- Anal fissures
- Hemorrhoids

Drink, Food, and Taste

- Unusual taste in mouth (i.e. bitter)
- Bad breath
- Excessive saliva
- Mouth sores
- Cracked, dry lips
- Lip tremors
- Tongue disorders

Craving for (flavors): _____

Food, Drink, and Taste

- Loose teeth or toothache
- Extensive dental decay
- Grinding of the teeth
- Painful, swollen, or bleeding gums
- Poor appetite
- Excessive hunger
- Indigestion
- Hiccup
- Belching
- Acid regurgitation
- Nausea
- Vomiting
- Vomiting of blood

Chest, Rib-side, Stomach, and Abdomen

- Chest pain
- Chest tightness
- Heat or unusual sweating of the chest
- Cough
- Coughing of blood
- Rapid, labored, hasty breathing
- Wheezing
- Shortness of breath when speaking
- Rapid beating of the heart
- Pains along the sides of the trunk
- Unusual armpit odor
- Difficulty swallowing
- Frequent yawning
- Stomach pain
- Burning stomach pain
- Pain in the area of the navel
- Abdominal fullness
- Abdominal swelling (ascites)
- Lower abdominal pain
- Rumbling intestines

Thirst and Intake of Beverages

- Thirst
- Dry mouth
- Lack of thirst
- Thirst unquenched by drinking
- Drinking without desire to swallow
- Liking for cold drinks
- Liking for warm drinks

Eyes, Ears, Nose, and Throat

- Eye pain
- Itchy or dry eyes
- Red eyes
- Frequent tearing
- Sensitivity to light
- Frequent floaters in the visual field
- Night blindness
- Impaired vision
- Blindness
- Sty
- Swollen or drooping eyelids
- Ear ringing
- Itchy or painful ears
- Discharge from the ears
- Hearing impairment
- Nose pain
- Nosebleed
- Dry nose
- Runny nose
- Nasal congestion
- Nasal swelling
- Loss of sense of smell
- Sore, swollen throat
- Itchy or dry throat
- Hoarse voice
- Loss of voice
- Sense of a mass stuck in the throat without eating

Sleep

- Insomnia
- Difficulty falling asleep
- Easily being awakened
- Waking too early
- Profuse dreaming
- Excessive sleep

Women

Ages at first and last menses

Duration between menses

Color, quality, and quantity of bleeding

- Menses sometimes early, sometimes late
- Clotted menstrual blood
- PMT (PMS)
- Pain with menses

Vaginal discharge quality

Pregnancies

Births

Miscarriages

Abortions

Mental-Emotional

- Panic attacks
- Agitation
- Cognitive impairment
- Poor memory
- Impaired speech
- Depression
- Easy anger
- Nervous laughter
- Anxiety
- Obsessive thoughts
- Persistent sorrow
- Frequently fearful
- Easily startled

Additional Personal Medical History

- | | | |
|---|--|---|
| <input type="checkbox"/> Abuse survivor | <input type="checkbox"/> Eczema | <input type="checkbox"/> Neurological disease |
| <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Phlebitis |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Excess phlegm | <input type="checkbox"/> Pleurisy |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Enlarged thyroid | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Fungal infections | <input type="checkbox"/> Polio |
| <input type="checkbox"/> Birth trauma | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Psoriasis |
| <input type="checkbox"/> Blood clots | <input type="checkbox"/> Goiter | <input type="checkbox"/> Rheumatic fever |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Gout | <input type="checkbox"/> Scarlet fever |
| <input type="checkbox"/> Cardiovascular disease | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Herpes | <input type="checkbox"/> STD's |
| <input type="checkbox"/> Changes in libido | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Chicken pox | <input type="checkbox"/> Kidney stones | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Concussions | <input type="checkbox"/> Laxative use | <input type="checkbox"/> Typhoid |
| <input type="checkbox"/> Considered/attempted suicide | <input type="checkbox"/> Malaria | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> COPD | <input type="checkbox"/> Measles | <input type="checkbox"/> Valley fever |
| <input type="checkbox"/> Dandruff | <input type="checkbox"/> Mumps | <input type="checkbox"/> Whooping cough |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Muscle cramps | |

Other:

Family Medical History

- | | | |
|-------------------------------------|---|--|
| <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> Cancer | <input type="checkbox"/> High blood pressure |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Cardiovascular disease | <input type="checkbox"/> Mental disorder |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Neurological disorder |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Seizures |
| | | <input type="checkbox"/> Stroke |

Other:

Thank you for your assistance and patience.
Enjoy your treatment!