

Health History Questionnaire

All information is confidential.

Information for your Acupuncturist.

Please complete this document as thoroughly as possible. Some of the questions that follow may seem unrelated to your condition, however, they may play a major role in diagnosis and treatment.

General Patient Information

Date: _____ / _____ / _____

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Email: _____ Would you like to receive our e-mail newsletter? YES NO

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

Marital Status: Married Single Divorced Widowed Domestic Partnership Other

Name of Spouse/Partner/Other: _____

Guardian (if under 18): _____

Gender: MALE FEMALE Height: _____ Weight: _____

Social Security Number: _____ Drivers License Number: _____

Occupation: _____ Employer: _____

Employer Address: _____

City: _____ State: _____ Zip Code: _____

Goal from acupuncture or other services we offer: _____

Does anything limit you from care? NO YES (explain) _____

How did you hear about our office? _____

Other physicians/therapists seen for this: _____

Medications (if any): _____

Prescribed by: _____

Treatment(s): _____

Results: _____

Supplements/Vitamins/Herbs: _____



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919-619-2339

Major complaints, in order of significance to you:

	SEVERE	MODERATE	SLIGHT	NORMAL
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

How do these conditions impair your daily activities? _____

Patient Medical History

How was your childhood health? _____
Hospital Visits/Stays: _____

Recent tests (*indicate results and date below*)

- Physical Cholesterol Prostate Blood (which?) _____
- HIV/STD Pap smear Mammography Hormone (saliva)
- Thermography Other

Test Results and date: _____



Check any you have had in the past:

- | | | | |
|---|--|--|---|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Allergies | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> CVA (Stroke) | <input type="checkbox"/> Vein Condition | <input type="checkbox"/> Thyroid Disorder |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Emphysema |
| <input type="checkbox"/> Jaundice | <input type="checkbox"/> Gonorrhea | <input type="checkbox"/> Mumps | <input type="checkbox"/> Bleeding Tendency |
| <input type="checkbox"/> Syphilis | <input type="checkbox"/> Measles | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Nervous Disorder |
| <input type="checkbox"/> Meningitis | <input type="checkbox"/> HIV | <input type="checkbox"/> Polio | <input type="checkbox"/> Mononucleosis |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> High Fever | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Multiple Sclerosis |
| <input type="checkbox"/> Paralysis | <input type="checkbox"/> Cancer | <input type="checkbox"/> Migraines | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Other Lung Illness | <input type="checkbox"/> Other Liver Illness | <input type="checkbox"/> Other Heart Illness | <input type="checkbox"/> Other Kidney Illness |
| <input type="checkbox"/> Other Spleen Illness | <input type="checkbox"/> Other Stomach Illness | | |
| <input type="checkbox"/> Other: _____ | | | |

Immunizations: _____

Surgeries: _____

Family History:

Father	Alive	Deceased	Present Health/Cause of Death
_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Mother	Alive	Deceased	Present Health/Cause of Death
_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Spouse	Alive	Deceased	Present Health/Cause of Death
_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Child	Alive	Deceased	Present Health/Cause of Death
_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Child	Alive	Deceased	Present Health/Cause of Death
_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Sibling	Alive	Deceased	Present Health/Cause of Death
_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Sibling	Alive	Deceased	Present Health/Cause of Death
_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Sibling	Alive	Deceased	Present Health/Cause of Death
_____	<input type="checkbox"/>	<input type="checkbox"/>	_____



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Where are you in the birth order? First Last Middle Only Other: _____

Check the following that have occurred in your blood relatives:

- | | | | |
|---|---------------------------------------|--|--|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Obesity | <input type="checkbox"/> Bleeding Tendency |
| <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Nervous Illness | <input type="checkbox"/> Mental Illness |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Unsure | <input type="checkbox"/> Other: _____ | |

Patient Profile:

Please clearly mark below any areas of pain and any scars (indicate which are scars):

Is the pain:

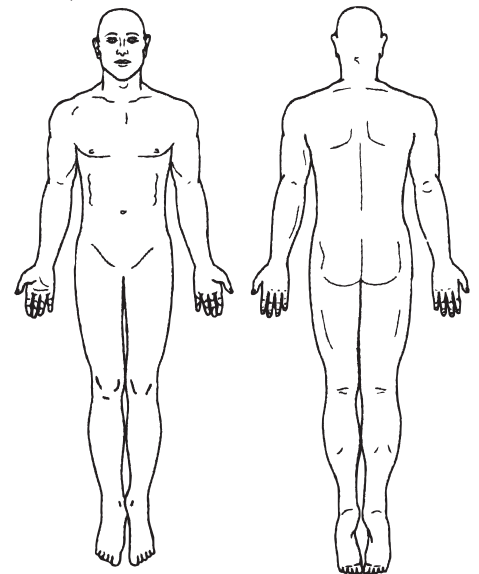
- | | | |
|-----------------------------------|---------------------------------------|---------------------------------|
| <input type="checkbox"/> Sharp | <input type="checkbox"/> Burning | <input type="checkbox"/> Aching |
| <input type="checkbox"/> Cramping | <input type="checkbox"/> Dull | <input type="checkbox"/> Moving |
| <input type="checkbox"/> Fixed | <input type="checkbox"/> Other: _____ | |

Do the following lessen the pain:

- | | | |
|-----------------------------------|---------------------------------------|-------------------------------|
| <input type="checkbox"/> Pressure | <input type="checkbox"/> Cold | <input type="checkbox"/> Heat |
| <input type="checkbox"/> Exercise | <input type="checkbox"/> Other: _____ | |

Do the following worsen the pain:

- | | | |
|-----------------------------------|---------------------------------------|-------------------------------|
| <input type="checkbox"/> Pressure | <input type="checkbox"/> Cold | <input type="checkbox"/> Heat |
| <input type="checkbox"/> Exercise | <input type="checkbox"/> Other: _____ | |



Please check the following that pertain to you:

Overall Temperature (Kidney Function):

- | | |
|--|--|
| <input type="checkbox"/> Cold hands | <input type="checkbox"/> Cold feet |
| <input type="checkbox"/> Sweaty hands | <input type="checkbox"/> Sweaty feet |
| <input type="checkbox"/> Hot body temperature (sensation) | <input type="checkbox"/> Cold body temperature (sensation) |
| <input type="checkbox"/> Afternoon flushes | <input type="checkbox"/> Night sweats |
| <input type="checkbox"/> Heat in the hands, feet, and chest | <input type="checkbox"/> Hot flashes any time of the day |
| <input type="checkbox"/> Thirsty | <input type="checkbox"/> Perspire easily |
| <input type="checkbox"/> Lack of perspiration | <input type="checkbox"/> Take water to bed |
| <input type="checkbox"/> Difficulty keeping eyes open in the daytime | |



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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

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 (# _____ cups/week)
- Knee pain

LUNG FUNCTION

- Nasal discharge (color: _____)
- Cough
- Nose bleeds
- Sinus congestion
- Dry mouth
- Dry throat
- Dry nose
- Dry skin
- Allergies (to what? _____)
- Alternating fever/chills
- Sneezing
- Headache (location? _____)
- Overall achy feeling in the body
- Stiff neck
- Stiff shoulders

- Sore throat
- Difficulty breathing
- Smoke cigarettes (# _____ /day)
- 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 (which diagnosed? _____)
- Easily bruised
- Hemorrhoids
- Pensive
- Over-thinking
- Worry

SPLEEN, STOMACH, LARGE AND SMALL INTESTINE FUNCTION

- Loose stools
- Constipated
- Incomplete stools
- 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



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DAMPNESS TRAPPED IN THE BODY (cont.)

- 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
- Thirst with no desire to drink

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
(caused by? _____)
- 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
- Limited range-of-motion, neck
- Shoulder tension
- Limited range-of-motion, shoulder
- Drink alcohol
- Recreational drugs (which? _____)
(how much per week? _____)
- High pitched ringing in the ears
- Gall stones (past or present)
- Sexually transmitted disease
(which? _____)

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 sensations in the knees
- Low back pain
- Memory problems
- Excessive hair loss
- Low-pitched ringing in the ears
- Kidney stones
- Bladder infections
- Wake during the night twice or more to urinate



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KIDNEY, URINARY BLADDER FUNCTION (cont.)

- Lack of bladder control
- Fear
- Easily startled

- Strong odor
- Burning
- Painful
- Discharge
- Difficult
- Urgent
- Frequent

URINATION

- Normal color
- Dark yellow
- Clear
- Reddish
- Cloudy
- Scanty
- Profuse

LIBIDO

- Normal
- High
- Low
- Other symptoms: _____

Women Only:

Regular menstrual cycle? YES NO Pregnant? YES NO

Number of pregnancies: _____ Number of children: _____ Age of 1st menstruation: _____

Age of menopause: _____ Average # of days of flow: _____ Average # of days of cycle: _____

	SEVERE	MODERATE	SLIGHT	NORMAL
Vaginal Discharge:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding between periods:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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

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

Please fill out menstrual chart on following page.



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Please fill in the following menstrual chart (enter color)	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:

	SEVERE	MODERATE	SLIGHT	NORMAL
Swollen testes:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Testicular pain:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Impotence:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Premature ejaculation:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Coldness/numbness in external genitalia:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

All patients — please fill out:

Other comments: _____

Patient Signature: _____

Acupuncturist Signature: _____

