

Date: \_\_\_\_\_

## 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 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: \_\_\_\_\_ PHONE: H- \_\_\_\_\_ W- \_\_\_\_\_

CELL PHONE: \_\_\_\_\_ EMAIL: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

AGE: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_ PLACE OF BIRTH: \_\_\_\_\_

HEIGHT: \_\_\_\_\_ WEIGHT: \_\_\_\_\_ MARITAL STATUS: \_\_\_\_\_ SOCIAL SECURITY #: \_\_\_\_\_

EMPLOYER NAME: \_\_\_\_\_ OCCUPATION: \_\_\_\_\_

FAMILY PHYSICIAN: \_\_\_\_\_ REFERRED BY: \_\_\_\_\_

IN EMERGENCY NOTIFY: \_\_\_\_\_ PHONE: \_\_\_\_\_

HAVE YOU BEEN TREATED BY ACUPUNCTURE OR ORIENTAL MEDICINE BEFORE? YES \_\_\_\_\_ NO \_\_\_\_\_

Main problem(s) you would like us to help you with: \_\_\_\_\_

How long ago did this problem begin (be specific)?: \_\_\_\_\_

To what extent does this problem interfere with your daily activities (work, sleep, sex)?: \_\_\_\_\_

Have you been given a diagnosis for this problem? If so, what?: \_\_\_\_\_

What kinds of treatment have you tried?: \_\_\_\_\_

Past Medical History (please include date): Cancer \_\_\_\_\_ Diabetes \_\_\_\_\_

Hepatitis \_\_\_\_\_ High Blood Pressure \_\_\_\_\_ Heart Disease \_\_\_\_\_

Rheumatic Fever \_\_\_\_\_ Thyroid Disease \_\_\_\_\_ Seizures \_\_\_\_\_

Venereal Disease \_\_\_\_\_ Other \_\_\_\_\_

Surgeries (type of and date): \_\_\_\_\_

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

Significant Dental Work (type and date): \_\_\_\_\_

Birth History (prolonged labor, forceps delivery, etc.): \_\_\_\_\_

Allergies (drugs, chemicals, foods/result): \_\_\_\_\_

Family Medical History (check): Diabetes \_\_\_\_\_ Cancer \_\_\_\_\_ High Blood Pressure \_\_\_\_\_ Heart Disease \_\_\_\_\_  
Stroke \_\_\_\_\_ Seizures \_\_\_\_\_ Asthma \_\_\_\_\_ Allergies \_\_\_\_\_  
Other: \_\_\_\_\_

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

Occupational Stress (chemical, physical, psychological, etc.): \_\_\_\_\_

Do you have a regular exercise program? Yes \_\_\_\_\_ No \_\_\_\_\_ Please describe: \_\_\_\_\_

Have you ever been on a restricted diet? Yes \_\_\_\_\_ No \_\_\_\_\_ What kind?: \_\_\_\_\_

PLEASE DESCRIBE YOUR AVERAGE DAILY DIET:

Morning - \_\_\_\_\_

Afternoon - \_\_\_\_\_

Evening - \_\_\_\_\_

How many packs of cigarettes do you smoke per day? \_\_\_\_\_

How much coffee, tea or cola do you drink per week? \_\_\_\_\_

How much alcohol do you drink per week? \_\_\_\_\_

Please describe any use of drugs for non-medical purposes: \_\_\_\_\_

PLEASE CHECK ANY YOU HAVE HAD IN THE LAST THREE MONTHS

**GENERAL**

- Chills
- Fevers
- Sweat easily
- Night sweats
- Localized weakness
- Bleed or bruise easily
- Peculiar tastes or smells
- Strong thirst (cold or hot)
- Thirst, no desire to drink
- Fatigue
- Sudden energy drop
- Time of day? \_\_\_\_\_
- Edema
- Where \_\_\_\_\_
- Poor sleeping
- Tremors
- Poor balance
- Cravings

- Change in appetite
- Poor appetite
- Weight gain
- Weight loss

**SKIN AND HAIR**

- Rashes
- Itching
- Change in hair or skin
- Ulcerations
- Eczema
- Oozing on skin lesion
- Hives
- Pimples
- Recent moles
- Loss of hair
- Dandruff
- Other hair or skin problems: \_\_\_\_\_

**HEAD, EYES, EARS, NOSE AND THROAT**

- Dizziness
- Migraines
- Headaches
- when: \_\_\_\_\_
- Where: \_\_\_\_\_
- Facial pain
- Glasses
- Poor vision
- Night blindness
- Blurry vision
- Color blindness
- Blind field
- Spots in front of eyes
- Eye pain
- Eye strain
- Cataracts
- Eye dryness

- Excessive tear
- Discharge from eyes
- Poor hearing
- Ringing in ears
- Earaches
- Discharge from ear
- Nose bleeds
- Sinus congestion
- Nasal drainage
- Grinding teeth
- Teeth problems
- Jaw clicks
- Concussions
- Recurrent sore throats
- Hoarseness
- Sores on lips or tongue

Other head or neck problems: \_\_\_\_\_

### CARDIOVASCULAR

- High blood pressure
- Low blood pressure
- Chest discomfort/pain
- Heart palpitations
- Cold hands or feet
- Swelling of hands
- Swelling of feet
- Blood clots
- Fainting
- Difficulty in breathing

Other heart or blood vessel problems: \_\_\_\_\_

### RESPIRATORY

- Cough
- Asthma/wheezing
- Pain with a deep breath
- Difficulty in breathing when lying down
- Production of phlegm what color: \_\_\_\_\_
- Coughing blood
- Pneumonia
- Bronchitis

Other lung problems: \_\_\_\_\_

### GASTROINTESTINAL

- Bad breath
- Nausea
- Vomiting
- Heartburn
- Belching

- Indigestion
- Diarrhea
- Constipation
- Chronic laxative use
- Blood in stools
- Black stools
- Abdominal pain or cramps
- Gas
- Rectal pain
- Hemorrhoids

Other stomach or intestinal problems: \_\_\_\_\_

### GENITO-URINARY

- Pain on urination
- Urgency to urinate
- Frequent urination
- Blood in urine
- Decrease in flow
- Unable to hold urine
- Dribbling
- Kidney stones
- Impotency
- Change of sexual drive
- Sores on genitals

Other genital or urinary system problems: \_\_\_\_\_

Do you wake up to urinate?

Yes No

How often? \_\_\_\_\_

Any particular color to your urine: \_\_\_\_\_

### PREGNANCY AND GYNECOLOGY

- Number of pregnancies
- Number of births
- Premature births
- Miscarriages
- Abortions
- Age at first menses
- Period between menses
- Duration
- First date of last menses
- Unusual character (heavy or light)
- Painful periods
- Irregular periods
- Changes in body/psyche prior to menstruation
- Clots
- Menopause: Age \_\_\_\_\_ yr
- Vaginal discharge
- Postcoital bleeding

- Vaginal sores
  - Last Pap
  - Breast lumps
  - Nipple discharge
- Do you practice birth control?  
Yes No

What type and for how long?  
\_\_\_\_\_  
\_\_\_\_\_

### MUSCULOSKELETAL

- Neck pain
- Shoulder pain
- Back pain
- Elbow pain
- Hand/wrist pains
- Hip pain
- Knee pain
- Foot/ankle pains
- Muscle pains
- Muscle weakness

### NEUROPSYCHOLOGICAL

- Seizures
  - Areas of numbness
  - Weakness
  - Sleep disorder
  - Concussion
  - Bad temper
  - loss of control/violence potential
  - Vertigo
  - Lack of coordination
  - Depression
  - Easily susceptible to stress
  - Loss of balance
  - Poor memory
  - Anxiety
  - Substance abuse
- Other neurological or psychological problems  
\_\_\_\_\_  
\_\_\_\_\_

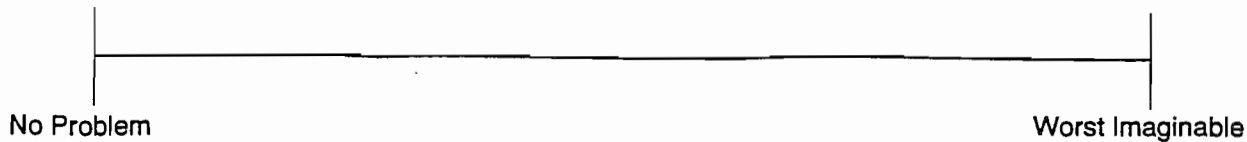
Have you ever been treated for emotional problems?

Yes No

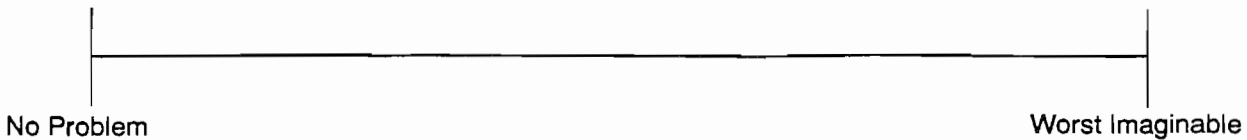
Have you ever considered or attempted suicide?

Yes No

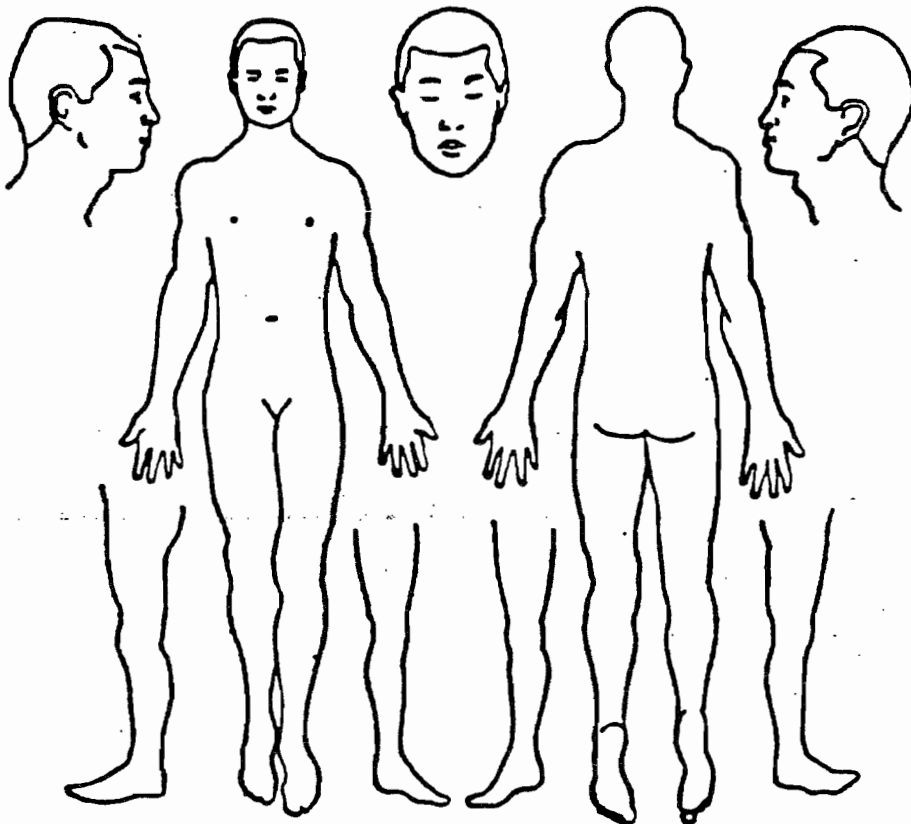
PLEASE NOTE THE DEGREE OF SEVERITY OF YOUR PROBLEM NOW:



PLEASE NOTE THE GREATEST DEGREE OF SEVERITY OF YOUR PROBLEM WITHIN THE LAST WEEK:



INDICATE PAINFUL OR DISTRESSED AREAS:



COMMENTS (please tell us any other problems you would like to discuss): \_\_\_\_\_

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