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Acupuncture Health History Questionnaire

Please help us provide you with a complete evaluation by taking the time to fill out this questionnaire carefully. Even though some of the questions may seem unrelated to your condition, they may play a contributing role in diagnosis and treatment. All of your information will be confidential and if you have any questions, please ask. Thank you.

Contact Information Today's Date:___/___/______

Name:____ Sex: F ☐ M ☐ DOB:___/___/____ Age:____

Street:____ Email Address:_________________________

City:____________________ State:_____ Zip:__________ Phone Number:______________________

Martial Status: M ☐ S ☐ D ☐ W ☐ # of Children:_____ Alternative Phone Number:_______________

Occupation:_________________________ Employer:____

Emergency Contact:_________________________ Phone:____________________

Have you had acupuncture before? Y ☐ N ☐

Insurance Carrier:____________________ ID #:_________________ Group #:______________

Name of Insured:_________________________ Relationship to Patient: Self ☐ Spouse ☐ Parent ☐

Customer Service Phone Number:____________________

Height: ____________________ Weight: ___________lbs.

Major Health Complaint(s)

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

____

When did the checked problem begin?____

What are the precipitating factors?____

Have you been given a diagnosis for this problem? If so, what and by whom?

____

What kind of treatments have you tried?____

What makes this problem worse?_________________________ Better?_________________________

Is there anybody in your family with the same problem?____

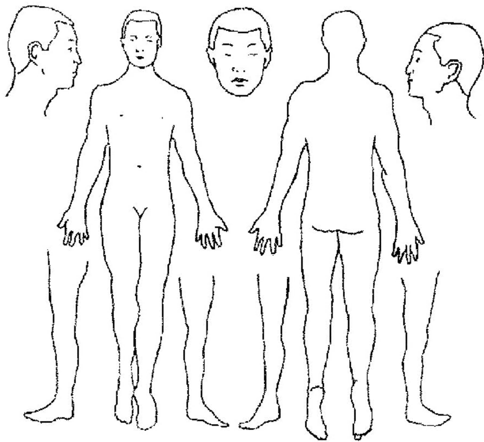
Please describe how these conditions affect or impair your daily activities? Examples may include your overall quality of life, work, family life, hobbies or self-esteem.

____

What kinds of treatment have you tried? ___________________________________

What response/results did you have? ___________________________________

Please indicate painful or distressed areas by using the symbol that best describes the feeling:



Mark with appropriate symbols:
XXX Sharp / Stabbing
PPP Pins and Needles
DDD Dull / Aching
NNN Numbness

Please rate your **current** level of pain: Very mild 1 2 3 4 5 6 7 8 9 10 Very severe

Past Medical History

Check any conditions that you have had in the past or are currently experiencing: **P=Past C=Current**

P	C	Condition	P	C	Condition	P	C	Condition	P	C	Condition
☐	☐	Alcohol/Drug Abuse	☐	☐	Digestive Disorder	☐	☐	Hypertension	☐	☐	Nervous Disorder
☐	☐	Anemia	☐	☐	Epilepsy/Seizures	☐	☐	Jaundice	☐	☐	Pneumonia
☐	☐	Arthritis	☐	☐	Glaucoma	☐	☐	Kidney Disease	☐	☐	Stroke
☐	☐	Asthma	☐	☐	Heart Disease	☐	☐	Liver Disease	☐	☐	Thyroid Disorder
☐	☐	Auto Immune	☐	☐	Heavy Bleeding/Hemorrhage				☐	☐	Tuberculosis
☐	☐	Blood Transfusion	☐	☐	Hepatitis	☐	☐	Mental Illness	☐	☐	Vein Condition
☐	☐	Cancer	☐	☐	High Cholesterol	☐	☐	Migraines	☐	☐	Venereal Disease
☐	☐	Diabetes	☐	☐	HIV/Hepatitis	☐	☐	Other:____________________			

Known allergies (food, medications, or other):____

Significant trauma (car accident, sports injuries etc.):_______________________________________

Immunizations:____

Hospitalizations/Surgeries (procedures and dates):____________________________________

Dental Procedures (include any silver fillings/mercury amalgams):____________________________

Do you have a history of frequent antibiotic use? Please Describe.____________________________

Allergy shots? Currently ☐ In the past ☐ Never ☐

Please briefly describe your health as a child. (e.g. allergies/asthma, prone to illness, etc):

____

Other relevant medical history:

____

____

Family Medical History (please specify family member)

☐Alcoholism/Drug Abuse____________________ ☐Heart Disease____________________________

☐Asthma/Allergies_________________________ ☐Hypertension_____________________________

☐Cancer________________________________ ☐Miscarriage_______________________________

☐Depression/Mental Illness__________________ ☐Osteoporosis______________________________

☐Diabetes_______________________________ ☐Stroke___________________________________

☐Other____

Current Health & Lifestyle

Do you smoke? Y ☐ N ☐ If yes, how many per day?_____ For how long?_____

Do you exercise? Y ☐ N ☐ If yes, how many times per week?_____ Please Describe.____________

How many hours do you sleep in general?_____ When do you usually go to bed?_____

Overall, do you feel that your lifestyle contributes to or takes away from your health?

____

Diet

Soft drinks per day_____ Cups of tea per day_____ Cups of coffee per day_____

Glasses of water per day_____ Alcoholic beverages per week_____

Are you a vegetarian? Y ☐ N ☐ Yes, but not strict ☐ Explain:__________________________

Please describe your average daily diet:

Breakfast:____

Lunch:____

Dinner:____

Snacks:____

Foods you tend to crave:____

Medications and Supplements

Medications you are currently taking (please include prescription medicines, vitamins, supplements, over the counter drugs, herbal supplements, etc.):

____

____

____

____

Profile

Please check any of the following symptoms that **currently** pertain to you.

General

☐Cold hands	☐Hot body temperature	☐Profuse perspiration	☐Chills
☐Cold feet	☐Cold body temperature	☐Lack of perspiration	☐Fever
☐Sweaty hands	☐Afternoon flushing	☐Perspire easily	☐Strong thirst
☐Sweaty feet	☐Hot flashes	☐Night sweating	☐Lower back pain
☐Frequent cavities	☐Hearing loss	☐Weak knees	☐Cold lower back
☐Broken/loose teeth	☐Ringing in ears/tinnitus	☐Knee soreness	☐Cold hips/buttocks
☐Weak bones	☐Early graying of hair	☐Hair loss	☐Cold knees
☐Dizziness	☐Forgetfulness	☐Fainting	☐Weak nails

Emotions

☐Mood swings	☐Anxiety	☐Fits of laughter	☐Fear
☐Sadness	☐Panic attacks	☐Depression	☐Frequent worrying
☐Nervousness	☐Irritability	☐Anger	☐Easily stressed
☐Bipolar	☐Obsessive/Compulsive	☐Mania	

Skin

☐Acne	☐Dry or Flaky Skin	☐Hives	☐Rashes
☐Dandruff	☐Eczema	☐Psoriasis	☐Ulcerations/Boils

Neuro-Muscular

☐Seizures ☐Lack of coordination ☐Tingling in extremities ☐Numbness
☐Paralysis ☐Loss of balance ☐Muscle spasms

Cardiovascular

☐Heart palpitations ☐Chest Pain/Angina ☐Tongue ulcers ☐Speech impediment
☐Restless dreams ☐Mental restlessness ☐Insomnia ☐Hallucinations

Respiratory

☐Persistent cough ☐Nasal dryness ☐Chest congestion ☐Chest tightness
☐Nosebleeds ☐Chronic allergies ☐Sneezing ☐Difficulty Breathing
☐Sinus congestion ☐Sore throats ☐Wheezing ☐Shortness of breath
☐Frequent colds/flu

Gastrointestinal

☐Indigestion ☐Low or weak appetite ☐Fatigue following a meal ☐Hypoglycemia
☐Abrupt weight gain ☐Gurgling in intestines ☐Easily fatigued ☐Strong cravings
☐Abrupt weight loss ☐Bruise easily ☐Gas ☐Hemorrhoids
☐Stomach ache ☐Ravenous appetite ☐Stomach ulcer ☐Nausea
☐Acid reflux ☐Bleeding gums ☐Belching ☐Vomiting
☐Bad breath ☐Heartburn ☐Hiccups ☐Mouth ulcers
☐Loose stools ☐Blood in stools ☐Less than 1 BM per day ☐Constipation
☐Mucous in stools ☐Difficulty moving bowels ☐Small, hard, dry stools ☐Diarrhea

Lymphatic System/Accumulated Dampness

☐Swollen hands ☐Mental fogginess ☐Edema in the legs ☐Heavy limbs/head
☐Swollen feet ☐Mental sluggishness ☐Edema in the abdomen ☐Joint stiffness

Liver/Gall Bladder Function

☐Headaches ☐Migraines ☐Pain in ribcage ☐Gall stones ☐Chronic neck or shoulder tension

Eyes

☐Itchy eyes ☐Watery eyes ☐Poor night vision ☐Cataracts
☐Dry eyes ☐Red and irritated eyes ☐Floaters/Seeing spots ☐Glaucoma
☐Blurry vision

Urinary

☐Cloudy ☐Small amount ☐Night-time urination ☐Incontinence
☐Dark yellow ☐Large amount ☐Difficulty initiating urination ☐Strong odor
☐Clear color ☐Dribbling ☐Very frequent ☐Pain or burning
☐Reddish color

Male

☐Prostate Problems ☐Testicular pain/swelling ☐Ejaculation problems
☐Low sex drive ☐Premature ejaculation ☐Erectile dysfunction/impotence
☐Nocturnal emission ☐Infertility ☐Difficulty maintaining an erection
☐Low sperm count ☐Poor sperm motility ☐Irregular sperm morphology
☐Feeling of coldness or numbness of genitalia ☐Discharge

Do you have any other bothersome symptoms? Y ☐ N ☐ Describe:________________________

Do you get up at night to urinate? Y ☐ N ☐ How often?___________________________________

To what extent do these conditions interfere with your daily activities (work, sleep, socializing, sex, etc.)?

____

Have you sought medical intervention for these problems? If so, when?________________________

____

What treatment have you tried for these problems and how successful have they been?

____

Female

☐Pelvic infection	☐Endometriosis	☐Vaginal dryness	☐Frequent vaginal infections
☐Fibroids	☐Ovarian cysts	☐Abnormal pap smear	☐Abnormal vaginal discharge
☐Breast tenderness	☐Breast lumps	☐Spotting between periods	☐Hot flashes
☐Low sex drive	☐Fertility problems	☐Pain during intercourse	☐Night sweats

Do you experience any of the following associated with your period each month?

☐Water retention	☐Migraine/headache	☐Lower back pain	☐Change in bowel movement
☐Mood swings	☐Irritability	☐Abdominal cramps	☐Breast tenderness/swelling
☐Food cravings	☐Acne	☐Heavy bleeding	☐Scanty/light bleeding
☐Clots	☐Other:________________________________		

_____number of pregnancies _____number of live births _____miscarriages _____abortions

_____premature births _____difficult delivery _____cesareans

At what age did you get your first period:_____ First day of last menstrual period:__________________

Are your menstrual cycles spaced regularly? Y ☐ N ☐ Cycle length:______ Period length :______

Are you currently using birth control? Y ☐ N ☐ If yes, what type and for how long?_______________

Have you experienced menopause? Y ☐ N ☐ When?__________________________________

If you are experiencing menopausal symptoms, please describe:______________________________

____

Is there <u>any</u> possibility you are pregnant now? Y ☐ N ☐

____

Patient Signature Date