HEALTH HISTORY QUESTIONAIRE FOR PATIENTS

Welcome to our clinic! Please help us 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 us. 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:

Street: City: State: Zip:

Age: Height: Weight:

Home Phone: Work Phone:

Date/Place of Birth:

Occupation: Marital Status:

Emergency Contact:

Referred by:

Insurance Carrier: Policy Number:

Have you tried acupuncture or Chinese herbal medicine before?

MAIN PROBLEM(S) YOU WOULD LIKE TO ADDRESS

To what extent does this problem affect you daily activities (work, sleep, eating, etc.)?

How long has it been since you first noticed any symptoms?

Have you been given a diagnosis for the problem by your family physician?

If so, what is it?

What kinds of treatment have you tried?

PAST MEDICAL HISTORY (PLEASE INCLUDE DATES)

Allergies

Cancer

Diabetes

Hepatitis

High Blood Pressure

Seizures

Rheumatic Fever

Surgeries

Venereal Disease

Thyroid Disease

Birth Trauma (prolonged Labor, forceps delivery, ect.)

Other signifigant illness (describe)

Accidents or significant Trauma (describe)

OTHER RELEVANT MEDICAL HISTORY

FAMILY MEDICAL HISTORY

Allergies	Cancer	Seizures
Diabetes	Heart disease	Stroke
Asthma	High Blood Pressure	Other

OCCUPATION

Occupational stress factors (physical, psychological, chemical):

LIFESTYLE

Do you follow a regular exercise program? If so, please describe:

Please describe your average daily diet:

Please check any of the following habits that apply. How much and how often do you use them?

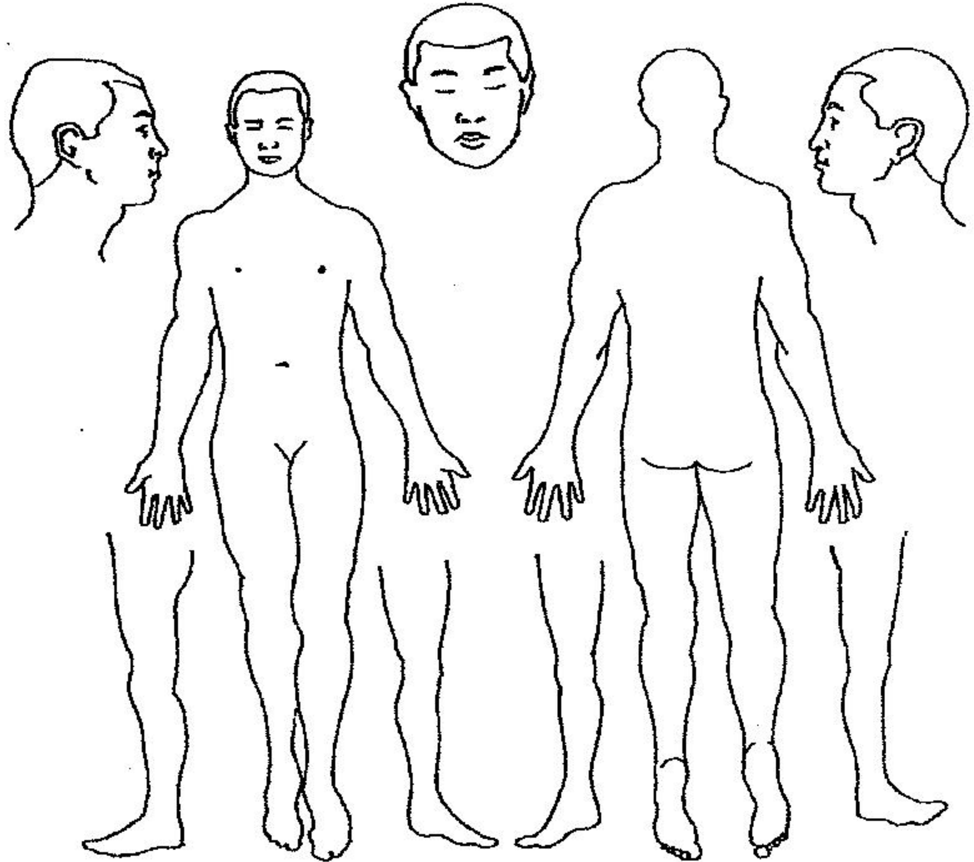
Cigarette Smoking	Coffee, tea, or cola	Alcoholic beverages

List any medications taken within the last two months (vitamins, drugs, herbs, etc.):

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

Symbol	Reaction
Pain on pressure	
x	Little
xx	Moderate
xxx	Strong
Swelling	
^	Slight
^^	Moderate
^^^	Severe
Tension & Weakness	
	Weak
#	Tense
Spontaneous pain	
†	Slight
††	Moderate
†††	Severe
Pulsing	
o	Slight
oo	Moderate
ooo	Strong
Temperature	
~	Colder
+	Hotter
Physical	
Ø	Sores
*	Rashes
<< >>	Spasms

PLEASE MARK ANY PAINFUL OR DISTRESSED AREAS ON THE CHART BELOW



PLEASE CHECK ANY CONDITIONS YOU HAVE EXPERIENCED WITHIN THE LAST THREE MONTHS. INDICATE THE LENGTH OF TIME YOU HAVE HAD THIS CONDITON.

GENERAL

- Poor appetite
- Insomnia
- Disturbed sleep
- Localized sleep
- Cravings
- Strong thirst

- Weight Gain
- Weight loss
- Changes in appetite
- Sweating easily
- Tremors
- Bleeding or bruising easily

- Night sweats
- Fever
- Chills
- Sudden energy drop (time of day?)
- Poor balance

Other unusual or abnormal conditions you have noticed in your general sense of health:

SKIN AND HAIR

Rashes	Eczema	Recent moles
Ulcerations	Pimples	Changes in texture of hair or skin
Hives	Dandruff	
Itching	Hair loss	

Any other hair or skin problems:

HEAD, EYES, EARS, NOSE , THROAT

Dizziness	Color blindness	Recurrent sore throats
Concussions	Cataracts	Nose bleeds
Migraines	Blurry vision	Grinding teeth
Glasses	Earaches	Sores on lips or tongue
Spots in front of eyes	Ringing in ears	Facial pain
Eye Pain	Poor hearing	Teeth problems
Poor vision	Eye strain	Headaches (where? when?)
Night blindness	Sinus problems	Jaw clicks

Any other head or neck problems:

CARDIOVASCULAR

Dizziness	High blood pressure	Swelling of feet
Low blood pressure	Fainting	Blood clots
Chest pain	Cold hands or feet	Difficulty in breathing
Irregular heartbeat	Swelling of hands	Phlebitis

Any other heart or blood vessel problems?

RESPIRATORY

Cough	Bronchitis	Difficulty breathing when lying down
Coughing up blood	Pain with deep inhalation	
Asthma	Pneumonia	Excessive phlegm (color?)

Any other lung problems?

GASTROINTESTINAL

Nausea	Belching	Rectal pain
Vomiting	Black stools	Hemorrhoids
Diarrhea	Blood in stools	Abdominal pain or cramps
Constipation	Indigestion	Chronic laxative use
Gas	Bad breath	

Any other problems with stomach or intestines?

GENITOURINARY

Pain on urination	Urgency o urinate	Decrease in flow
Frequent urination	Unable to hold urine	Impotence
Blood in urine	Kidney stones	Sores on genitals

Do you wake up at night to urinate?

Any particular color to your urine?

Any other genital or urinary problems?

REPRODUCTIVE AND GYNECOLOGIC

Premenstrual changes	Heavy menstrual flow	Premature births
Menstrual clots	Light menstrual flow	Miscarriages
Painful menses	Irregular menses	Abortions
Unusual menses	Other problems	

Age at first menses:	Age at first menopause:	Number of pregnancie s:
Time between cycles:	Duration of bleeding:	First day of last menses:
Do you practice birth control?	If so, what type?	For how long?

Any other gynecologic problems?

MUSCULOSKELETAL

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

Any other joint or bone problems?

NEUROPHYSICAL

Seizures	Poor memory	Anxiety
Dizziness	Lack of coordination	Bad temper
Loss of balance	Concussion	Easily susceptible to stress
Areas of numbness	Depression	

Have you ever been treated for emotional problems?

Have you ever considered or attempted suicide?

Any other neurological or psychological problems?

COMMENTS

Please list any other problems you would like to discuss: