HEALTH HISTORY QUESTIONNAIRE

Please complete the following questionnaire as thoroughly and honestly as possible. Please print your responses and indicate any areas of confusion with a question mark. Thank you.

Patient Name _____ **Birth date** _____ **Age**____ **M/F**__

ADDRESS_____**Phone**_____**Email**_____

1. What are the top 3 health concerns that you wish to address through acupuncture? (A = Most Important)

   A._____

   B._____

   C._____

2. Concerning your most important health concern mentioned above:

   (a) How long have you had this condition? _____

   (b) Have you had it or a similar condition before?

   (c) What does it feel like? _____

   (d) If painful, where does it hurt? _____

   (e) On a scale of 1 (not at all) to 10 (severely), how much does it impact your day-to-day life?

   (f) Is it related to emotions? If yes, how? _____

   (g) What makes it better? _____ (h) What makes it worse?

   _____

   (i) What diagnosis have you received?, (j) How are you treating it?_____

   (k) Are you under a physician's care for this condition? No Yes -> Physician:_____

   (l) May we contact the physician who is treating you? No Yes -> Phone #:_____

   (m) Are you under a physician's care for anything else? No Yes -» Physician:

   Condition: _____

LIFESTYLE & SOCIAL HISTORY

1. What type of work do you do? _____
2. What are your hobbies/pastimes? _____
3. Do you exercise? ___ If yes, what kind and how often? _____
4. Do you have a spiritual/meditative practice? ___ If yes, what kind?
5. Please check the following that apply: __Single __Married __Separated __Divorced __Widowed
6. Do you smoke or chew tobacco? ___ If yes, how much per day: _____ Date quit: _____
7. Do you currently use recreational drugs? ____ If yes, what kind and how often: _____

FAMILY HEALTH HISTORY _____ _____

The following questions pertain to your immediate family only.

1. Father (If living) - Age:___ If deceased-Age at time of death:____ Cause of death:_____
2. Mother (If living) - Age:___ If deceased-Age at time of death:____ Cause of death:_____
3. Number of children:____ If deceased-Age at time of death:____ Cause of death:_____

4. Please indicate if any member of your immediate family has or had any of the following conditions. Please do not include your personal health issues here. We'll get to that later.

Condition	Which immediate family member? (e.g., Parent/Grandparent/Sibling, etc.)
Acid Reflux / GERD	
Alcoholism / Smoking / Drug use	
Allergies	
Asthma, Emphysema, or other Breathing issues	
Birth Defects	
Blood Pressure issues	
Diabetes (specify type)	
Cholesterol issues	
History of Cancer	
History of Heart Disease	
History of Stroke	
Hypertension	
Kidney/Urinary issues	
Mental/Emotional issues	
Reproductive issues	
Thyroid issues	
Other:	
Other:	

PERSONAL MEDICAL HISTORY

1. Height: Weight:.
2. When was your last annual full-body physical examination? _____
3. **Do you have HIV, Hepatitis A/B/C, or any other infectious condition? Yes No**

   If other infectious disease, please identify: _____
4. Have you ever received acupuncture? Yes No -> If Yes, for what reason, and what was the result?

_____

5. Please list any sensitivities or allergies you may have to foods, drugs, medications, or environmental factors. Please include reaction: _____
6. Please list any birthmarks:_____
7. Please list any tattoos, body piercings or scars:_____
8. List major childhood illnesses and the age at which you had them: _____

9. Was there trauma with your birth (i.e., breech, premature, etc.)? _____
10. Have you experienced major physical or emotional trauma in your life (e.g., car accident, loss of a loved one, etc.)? ____ If yes, please describe to the level that you are comfortable:_____

11. Please list ALL Hospitalizations and Surgeries. Include ALL in-patient, out-patient, AND surgical cosmetic procedures. Use back of page if necessary.

_____

_____

_____

_____

12. Please list **ALL medications** (prescribed and OTC), **vitamins, herbs,** and other **supplements** you currently take and for what conditions. Use back of page if necessary:

Medication	Dosage/Frequency	Condition Treated

These questions will help us develop a comprehensive picture of your past and current state of health. Please be as honest as possible.

A. Face /Head /Hair

Please check the following if you have received a diagnosis for the listed condition or are currently experiencing any of the symptoms listed. Circle items that occurred only in the past.

- ☐ Unexplained facial pain or swelling
- ☐ Premature gray
- ☐ Malar flush (red across cheeks)
- ☐ Frequent headaches (see below)
- ☐ Chronic hair breakage/split ends
- ☐ Unexplained hair loss/thinning
- ☐ Often have dark circles under eyes
- ☐ Excessively oily hair or scalp
- ☐ Excessively dry hair or scalp
- ☐ Diagnosed w/ Trigeminal Neuralgia
- ☐ Diagnosed w/ Bell's Palsy
- ☐ Other:_____

If you checked "Frequent headaches", please check all that apply. Circle items that occurred only in the past.

- ☐ Frequent stress/tension headache
- ☐ Headache with physical exertion
- ☐ Head feels like it will "split in two"
- ☐ Frequent migraines
- ☐ One-sided headache
- ☐ Teeth hurt w/ headache
- ☐ Head hurts at sinuses / eyes
- ☐ Head hurts across forehead
- ☐ Head hurts at temples
- ☐ Head hurts at base of skull / neck
- ☐ Face hurts at mandible/jaw
- ☐ Light sensitive w/ headache
- ☐ Headache when hungry
- ☐ "Caffeine headache" (withdrawal)
- ☐ Head hurts in morning only
- ☐ Head hurts in afternoon/evening
- ☐ Nausea with headache
- ☐ Other:_____

G. Eyes/Vision

Please check the following if you have received a diagnosis for the listed condition or are currently experiencing any of the symptoms listed. Circle items that occurred only in the past.

- ☐ Recent change in vision
- ☐ Wear Glasses/Contacts
- ☐ Diagnosed Nearsighted
- ☐ Diagnosed Farsighted
- ☐ Diagnosed w/ Astigmatism
- ☐ Recurrent eye infections
- ☐ Night blindness
- ☐ Floaters or "spots"
- ☐ Eye strain or pain
- ☐ Recurrent eye tics or twitches
- ☐ Frequent tears in eyes
- ☐ Cross-eyed or Lazy Eye
- ☐ Blurry vision
- ☐ Glaucoma or Cataracts
- ☐ Laser/other surgery to correct vision
- ☐ Burning, redness, itching, dryness
- ☐ Other:_____
- ☐ Other:_____

B. Skin/Nails

Please check the following if you have received a diagnosis for the listed condition or are currently experiencing any of the symptoms listed. Circle items that occurred only in the past.

- ☐ Dry, flaky skin
- ☐ Oily skin
- ☐ Eczema / Psoriasis
- ☐ Yellowing of skin / Jaundice
- ☐ Sensitive skin
- ☐ Petechiae (blood spots under skin)
- ☐ Rashes, hives, or itchy skin
- ☐ Acne
- ☐ Frequent fungal infections
- ☐ Recent moles or mole changes
- ☐ Nail issues (weak, brittle, ridged)
- ☐ Acne Rosacea

D. Ears /Hearing

Please check the following if you have received a diagnosis for the listed condition or are currently experiencing any of the symptoms listed. Circle items that occurred only in the past.

- ☐ Hearing loss or deafness
- ☐ Frequent earaches
- ☐ Tubes in ears as child or adult
- ☐ Frequent ear itch, pain or discharge
- ☐ Tinnitus / Ringing in the ears
- ☐ Other:_____

E. Mouth/ Throat / t aste

Please check the following if you have received a diagnosis for the listed condition or are currently experiencing any of the symptoms listed. Circle items that occurred only in the past.

- ☐ Teeth grinding or clenching
- ☐ Diagnosed w/ TMJ issues
- ☐ Gum, tooth, or tongue problems
- ☐ Difficulty chewing
- ☐ Loose teeth
- ☐ Poor sense of taste
- ☐ Unusual or bad taste in mouth
- ☐ Chapped or sore lips
- ☐ Sore or Bleeding gums
- ☐ Diagnosed gingivitis
- ☐ Frequent sore throat
- ☐ Excess saliva/phlegm
- ☐ Dry mouth or throat
- ☐ Excess cavities
- ☐ Frequent loss of voice / hoarseness

F. Respiratory/Sinus Please check any that apply:

- ☐ Diagnosed w/ Asthma / Emphysema /COPD
- ☐ Difficulty breathing when lying flat
- ☐ Difficulty getting full breath
- ☐ Often short of breath
- ☐ Chronic wheezing
- ☐ Use a Neti pot for sinus irrigation
- ☐ Overly productive cough / excessive Phlegm
- ☐ Cough that is worse in evening
- ☐ Cough up blood or tinged sputum
- ☐ Dry cough with little sputum
- ☐ Cough with "tickle" in throat
- ☐ Chronic / Hacking cough
- ☐ Poor or no sense of smell
- ☐ Excess sinus mucus or drainage
- ☐ Excessive sneezing
- ☐ Frequent dry nose or nosebleeds
- ☐ Tip of nose feels cold to the touch
- ☐ Frequent sinus pain or pressure

G, Heart / Circulatory

Please check the following if you have received a diagnosis for the listed condition or are currently experiencing any of the symptoms listed. Circle items that occurred only in the past.

- ☐ Sweat with little or no exertion
- ☐ Diagnosed Hyperthyroid
- ☐ Diagnosed Hypothyroid
- ☐ Goiter / Enlarged thyroid
- ☐ Dizzy when stand up quickly
- ☐ History of fainting
- ☐ History of Rheumatic fever
- ☐ Pricking/stabbing chest pain that
- ☐ radiates down left arm
- ☐ Wear a Pacemaker
- ☐ Diagnosed w/ Hypertension©
- ☐ Heat intolerance / Often feel hot
- ☐ Hot hands and feet
- ☐ Bleed / Bruise easily
- ☐ Take blood thinners
- ☐ Blood pressure issues
- ☐ Deep leg pain
- ☐ Swelling of extremities / Edema
- ☐ Irregular heartbeat, palpitation or
- ☐ Murmur
- ☐ History of blood clots
- ☐ Hemophilia / Bleeding disorder
- ☐ Cold intolerance / Often feel cold
- ☐ Cold hands and feet
- ☐ Heat or fever in afternoon/eve
- ☐ History of heart attack
- ☐ Diagnosed w/ Heart Disease
- ☐ Arteriosclerosis / Hardening arteries
- ☐ Diagnosed w/ Low Iron or Anemia
- ☐ Unusual chest pain, tightness, pressure, or discomfort
- ☐ Varicose or spider veins

Mitral valve prolapse (MVP)

I. Diet / Digestion

(1) What foods do you eat most often?_____

(2) List any foods that cause burping, bloating, diarrhea, etc.? _____

(3) The flavors that you prefer or dislike actually say a lot about your energetic makeup. Please select Prefer, Dislike, or N/**A for the following. If you prefer a food but avoid it for** diet or health reasons, please check "Prefer" anyway.

Sweet (e.g., milk chocolate, carbohydrates)	☐ Prefer	☐ Dislike	☐ N/A
Sour (e.g., vinegar)	☐ Prefer	☐ Dislike	☐ N/A
Bitter (e.g., dark chocolate, bitter greens)	☐ Prefer	☐ Dislike	☐ N/A
Pungent (e.g., garlic, ginger)	☐ Prefer	☐ Dislike	☐ N/A
Salty	☐ Prefer	☐ Dislike	

(4) Please check the following if you have received a diagnosis for the listed condition or are currently experiencing any of the symptoms listed. Circle items that occurred only in the past.

- ☐ Sudden change in appetite/thirst
- ☐ Unexplained Nausea / Vomiting
- ☐ Vomit blood
- ☐ Burning and pain in chest or stomach area, especially after a meal
- ☐ Unexplained weight gain or loss
- ☐ Gall Bladder removed
- ☐ High Cholesterol
- ☐ Liver or Gall Bladder disease
- ☐ Excess thirst
- ☐ Excessive hunger
- ☐ Eating Disorder (Anorexia/Bulimia)
- ☐ B-12 or Folic Acid deficiency
- ☐ Consume dairy
- ☐ Diagnosed w/ Acid Reflux / GERD
- ☐ Excessive belch, burp, bloating/gas
- ☐ Eat excessively large meals
- ☐ Frequent hiccups
- ☐ Offensive, acidic breath
- ☐ Sour burp/regurgitation
- ☐ Use antacids regularly
- ☐ Gastric or Duodenal ulcers
- ☐ Frequently feel "lump in throat"
- ☐ Eat a "raw food" diet
- ☐ Diagnosed w/ Hiatal Hernia
- ☐ Use artificial sweeteners
- ☐ Consume wheat
- ☐ Diagnosed Type 1 Diabetes
- ☐ Diagnosed Type 2 Diabetes
- ☐ Diagnosed Hypoglycemia
- ☐ Irritable/lightheaded/low energy if meals missed
- ☐ Tired or sluggish after meals
- ☐ Feel bloated after meals
- ☐ Poor appetite
- ☐ Prefer cold food/liquids
- ☐ Prefer hot food/liquids
- ☐ Eat a vegetarian/vegan diet
- ☐ Hepatitis (A, B or C: ____)
- ☐ Eat a lot of soy
- ☐ Other:

J. Bowels /Elimination

(1) How often do you defecate (#2) each day?_

(2) How often do you use laxatives?_____

(3) Elimination issues & Stool quality ~ Please check the following if you have received a diagnosis for the listed condition or are currently experiencing any of the symptoms listed. Circle items that occurred only in the past.

- ☐ Crohn's Disease or Colitis
- ☐ Irritable Bowel Syndrome (IBS)
- ☐ Appendicitis / Appendix removed
- ☐ Frequently have offensive gas
- ☐ Excessive gurgling sounds in belly
- ☐ Frequently constipated
- ☐ Frequent diarrhea like water
- ☐ Alternating constipation/diarrhea
- ☐ Anal itching / burning
- ☐ Prolapse of anus or hemorrhoids
- ☐ Bowels do not empty completely
- ☐ Frequently have explosive diarrhea

Stool Quality:

- ☐ Normal, like a brown banana
- ☐ Black or dark D Contains blood
- ☐ Contains mucus
- ☐ Contains undigested food
- ☐ Liquid, like water
- ☐ Often loose/poorly formed
- ☐ Loose stool in the morning
- ☐ Hard, dry, or small stool
- ☐ Pasty stool (requires much wiping)
- ☐ Has offensive odor
- ☐ Other

K. Urinary / Kidneys

(1) How many times do you urinate (#1) each day?_____

(2) Do you drink caffeinated beverages? ___ How many ounces per day:

(3) How many ounces of non-caffeinated, non-carbonated water do you drink daily? _____

(4) Do you drink alcoholic beverages? ___ How many drinks per week: ____ Beverage of choice: _____

(5) Urinary issues & Quality ~ Please check the following if you have received a diagnosis for the listed condition or are currently experiencing any of the symptoms listed. Circle items that occurred only in the past

☐ Frequent, urgent urination
☐ Wake frequently to urinate
☐ Bladder does not fully empty
☐ Prostate Issues
☐ Lower abdomen feels "heavy"
☐ Incontinence/urine leakage
☐ Frequent UTI, cystitis, infections
☐ History of bedwetting
☐ Kidney/Bladder disease or Nephritis
☐ Kidney Stones

Urine Quality:

☐ Normal Quality
☐ Large amount
☐ Small amount
☐ Blood in urine
☐ Difficult or dribbling
☐ Painful or burning
☐ Clear in color
☐ Dark in color
☐ Turbid or Sandy
☐ Foul smelling
☐ Smells sweet

L. Reproductiove/Sexual Health ~ Male

For the following, please check all that apply. Circle items that occurred only in the past.

☐ Unexplained change in sex drive
☐ Erectile or impotence issues
☐ Premature ejaculation
☐ Testicular Pain/Swelling
☐ Nocturnal emissions
☐ SDT
☐ History of sexual trauma
☐ Vasectomy
☐ Penile discharge, sore, pain

L. Reproductiove/Sexual Health ~ Female

(1) Age when menstruation (monthly period) began? _____
(2) # of Pregnancies:_____ # of Live births:_____ # of Abortions:_____ # of Miscarriages:_____
(3) Do you perform monthly self breast exams?_____
(4) Preferred method of birth contro?_____How long have you used this?_____
(5) Are you attempting to conceive?_____
(6) Are you pregnant?_____ If so, how far along?_____
(7) Have you started menopause?___ Yes____No__-(If Yes, please answer questions a. – d. below)
a.) Have you experienced any uterine bleeding since menopause began?_____
b.) Have you had a hysterectomy?_____
c.) Are you currently on hormone replacement therapy (HRT)?_____ What type?_____
(8) When was your last Ob-Gyn exam / PAP?_____
(9) Typical length of monthly menstrual cycle: (Usually 21-30 days) _____
(10) Typical length of period: (Usually 4-7 days) _____

Monthly Period an PMS symptoms ~ Please check any that apply.

☐ No flow or little (amenorrhea)
☐ Scanty / light
☐Heavy
☐ Dark or Bright Red blood
☐ Purple or black
☐ Congealed with blood clots
☐ Bleeding starts and stops
☐ Brownish-red or black (spotting)
☐ Spotting/bleeding between cycles

PMS Symptoms

☐ Headaches
☐ fatigue
☐ Nausea / Vomiting
☐ Bloating, Ab. pain
☐ Abdominal cramping
☐Breast tenderness
☐ Low back cramping or pain
☐Constipation
☐Diarrhea, loose stool
☐ Acne
☐ Feel cold
☐ Hot flashes / Night sweats
☐ Irritability
☐ Depression
☐ Genital sores, eruptions, itching

--------Misc. Reproductive or Sexual Health

- ☐ History of Sexual Trauma
- ☐ Vaginal pain, dryness
- ☐ Nausea / Vomiting
- ☐ Unusual nipple discharge
- ☐ Epidural for delivery
- ☐ Cervical/uterine/ovarian tumors
- ☐ Painful intercourse
- ☐ Endometriosis
- ☐ Fibrocystic breasts
- ☐ Abnorma vaginal discharge, odor, sores
- ☐ Breast implants or reduction
- ☐ History abnormal PAP's

M.Neurological/Emotional Mind

(1) On a scale of 1-10, what is your stress level?_____Check any that apply

(2) Top 3 stressors_____

- ☐ More emotional that in past
- ☐ Very organized
- ☐ easily angered, irritable
- ☐ Mood can change rapidly
- ☐ Racing thoughts
- ☐ Diagnosed Alzheimer's/Dementia
- ☐ Hospitalized or under professional care for mental issues
- ☐ Get "stuck" on thoughts or actions
- ☐ Chronic clutter-disorganized
- ☐ Chronic anxiety, tension, stress
- ☐ Poor memory, concentration
- ☐ Lack of balance/coordination
- ☐ Vertigo/Dizziness issues
- ☐ diagnosed Post-Traumatic Stress Disorder (PSTD)
- ☐ Often feel depressed, unmotivated
- ☐ Seasons & weather affects moods
- ☐ Timid, lack courage, indecisive
- ☐ Often feel nervous or afraid
- ☐ History of panic attacks
- ☐ Diagnosed emotional issues
- ☐ History of Seizures / Epilepsy / Tremors / Convulsions

N. Sleep/Energy

(1) What time do you go to sleep?_____ How many hours do you sleep each night?_____

(3) Please check any that apply.

- ☐ Fall asleep easily, sleep well
- ☐ Cannot easily fall asleep
- ☐ Cannot stay asleep
- ☐ Sleep well once asleep
- ☐ Having disturbing dreams
- ☐ Wake rested
- ☐ "Waking up thinking" during night
- ☐ Unexplained fatigue
- ☐ Snore/sleep apnea
- ☐ Chronic Fatigue
- ☐ Energy levels fluctuate
- ☐ Require sugar /caffeine for energy
- ☐ Legs nervous/twitch at night
- ☐ Experience night sweats
- ☐ Diagnosed w/Adrenal Exhaustion

O. Musculoskeletal (1) Please check any that apply.

- ☐ Stiff neck
- ☐ Faulty posture / slouch
- ☐ Recurrent back pain
- ☐ Compressed or Ruptured Disk
- ☐ Diagnosed w/Osteoarthritis
- ☐ Diagnosed w/ Fibromyalgia
- ☐ Tingling/numbness of extremities
- ☐ Amputation
- ☐Carpal Tunnel Syndrome
- ☐ Dupuytren's Synd.
- ☐ Swollen, stiff, or painful joints
- ☐ Diagnosed w/Sciatica
- ☐ Diagnoses w/Osteoporosis
- ☐ Diagnosed w/ Spinal Stenosis
- ☐History of paralysis
- ☐ Diagnosed w/ Fibromyalgia
- ☐ Freq. Sprains, strains, dislocations
- ☐ History of tendonitis/bursitis
- ☐ History of breaks/fractures
- ☐ Diagnosed w/Rheumatoid Arthritis
- ☐ Scoliosis
- ☐ History of Gout
- ☐ Artificial joints or limbs
- ☐ Other_____

O. Other Illness or Condition (1) Please check any that apply.

- ☐ Diagnosed w/ Mononucleosis Colitis
- ☐ Genetic disorder/ Birth defect
- ☐ Food, Chemical, or Drug Poisoning
- ☐ History of alcohol or other additions
- ☐ History of drug use
- ☐ Diagnosed w/ Scarlet Fever
- ☐ Chicken Pox / Shingles
- ☐ Diagnosed w/Mumps
- ☐ Diagnosed w/Measles
- ☐ Rubella / German Measles
- ☐ Multiple Sclerosis
- ☐ Diagnosed w/ Smallpox
- ☐ Diagnosed w/ Malaria
- ☐ Diagnosed w/HIV or AIDS
- ☐ Diagnosed w/ Typhoid Fever
- ☐ History of Tuberculosis
- ☐ Diagnoses w/ Lupus
- ☐ Cancer

I acknowledge that all the information provided is true and to the best of my knowledge.

_____ _____ _____

Patient or Legal Rep. Name (PRINT) Patient or Legal Rep. Name SIGNATURE DATE

_____

Legal Representative Relation to Patient