HEALTH HISTORY QUESTIONAIRE

Information for your Acupuncturist

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

All information is strictly confidential

I. General Patient Information

Date: ____/____/____

Name: Mr. /Mrs. /Ms. _____

Address: _____

City, State, Zip Code: _____

Home Phone: (_____) _____ Work: (_____) _____

Cell Phone: (_____) _____ Email: _____

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

Guardian (if under 18):_____

Emergency Contact (name and phone #):_____

Gender: □ M □ F Height: ___'____" Weight: _____lbs

Social Security Number: _____-_____-_____ Driver's License Number: _____

Occupation: _____ Employer: _____

How did you hear about our office? _____

Major Complaint(s), in order of significance to you:

1._____ 4. _____

2. _____ 5. _____

3. _____ 6. _____

How do these conditions impair your daily activities? _____

_____

II. Patient Medical History

How was your childhood health? _____

Hospital Visits/Stays: _____

_____

Recent tests: (please indicate test results and date below)

□ Physical □ Cholesterol □Prostate □ Blood (which?)

□HIV/STD □Pap Smear □Mammography □Other: _____

Test Results and Date: _____

Check any you have had in the past:

□Diabetes □Allergies □Glaucoma □Rheumatic Fever

□Heart Disease □CVA (stroke) □Vein Condition □Thyroid Disorder

□Asthma □Pneumonia □Tuberculosis □Emphysema

□Jaundice □Gonorrhea □Mumps □Bleeding Tendency

□Syphilis □Measles □Chicken Pox □Nervous Disorder

□Meningitis □HIV □Polio □Mononucleosis

□Epilepsy □High Fever □Hepatitis □Multiple Sclerosis

□Paralysis □Cancer □Migraines □High Blood Pressure

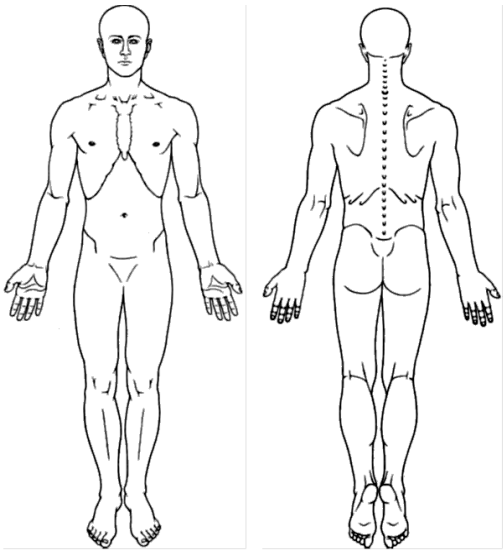
□other lung illnesses □other liver illnesses □other heart illnesses □other kidney illnesses

□Other:_____

Immunizations: _____

Surgeries: _____

III. Patient Profile



Is the pain:

□Sharp □Burning □Aching

□Cramping □Dull □Moving

□Fixed □Other: _____

Do the following improve the pain?

□Pressure □Cold □Heat

□Exercise □Other:_____

Do the following worsen the pain?

□Pressure □Cold □Heat

□Other:_____

Please check all of the following that currently pertain to you:

Overall Temperature (Yin & Yang)
The following symptoms indicate an imbalance of Yin and Yang in your body. In Oriental Medicine, Yin is the cool, moist, nourishing aspect of your body. Yang is the hot, dry, invigorating aspect of the body.

□Cold Hands
□Cold Fingers
□Cold Feet
□Cold Toes
□Sweaty Hands
□Sweaty Feet
□Hot Body Temperature (sensation)
□Cold Body Temperature (sensation)
□Afternoon Flushes
□Night Sweats
□Heat in the Hands, Feet, and Chest
□Hot Flashes Any Time of the Day
□Thirsty
□Perspire Easily
□Lack of Perspiration
□Take Water to Bed

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

Overall Blood (Liver, Spleen, Heart Function):

□Dizziness
□See Floating Black Spots

Heart Function:
The Following symptoms are indicators of heart malfunction. The heart governs the blood & blood vessels, manifests on the complexion, govern the emotions and effects speech and taste controls perspiration.

□Palpitations
□Anxiety
□Sores on the Tip of the Tongue
□Restlessness
□Mental Confusion

□Chest Pain Traveling to the Shoulder
□Frequent Dreams
□Wake Unrefreshed
□Drink Coffee (# of cups per week: _____)

Lung Functions:
The following symptoms are indicators of lung malfunction. The lungs govern breathing, control the movement of energy, control the immune system, regulate water passages, control the skin and open the nose, throat, and sinuses.

□Nasal Discharge (Color: _____)
□Cough
□Nose Bleeds
□Sinus Congestion
□Dry Mouth
□Dry Throat
□Dry Nose
□Dry Skin
□Allergies (To what? _____)
□Alternating Fever and Chills
□Sneezing
□Headache (Location: _____)
□Overall Achy Feeling in the Body
□Stiff Neck
□Stiff Shoulders
□Sore Throat
□Difficulty Breathing
□Smoke Cigarettes (# of cigarettes per day: _____)
□Sadness
□Melancholy

Spleen Function:
The following symptoms are indicators of spleen malfunction. The spleen assists in breaking food down into usable nutrients and then transports those nutrients throughout the body, keeps the blood in the blood vessels, governs the muscles, manifests in the lips and holds the organs up in the body.

□Low Appetite
□Abrupt Weight Gain
□Abrupt Weight Loss
□Abdominal Bloating
□Abdominal Gas
□Gurgling Noise in the Stomach
□Fatigue After Eating
□Prolapsed Organs (Previously diagnosed which organ? _____)
□Easily Bruised
□Hemorrhoids
□Pensive
□Over-thinking
□Worry

Spleen, Stomach, Large Intestine, Small Intestine Function:
□Loose
□Constipated
□Incomplete
□Diarrhea
□Blood in Stools
□Mucous in Stools
□Undigested Food in Stools

Dampness Trapped in the Body:
The following symptoms are indicators of "dampness", which simply refers to fluids that are not metabolized effectively and cause health problems in the body.

□General Sensation of Heaviness in the Body
□Mental Heaviness
□Mental Sluggishness
□Mental Fogginess
□Swollen Hands
□Swollen Feet
□Swollen Joints
□Chest Congestion
□Nausea
□Snoring

Stomach Function:
The following symptoms are indicators of stomach malfunction. The stomach controls the breakdown of food and nutrients, descends the energy and is the origin of the body's fluids.

□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

Liver, Gall Bladder Function:

The following symptoms are indicators of liver malfunction. The liver stores the blood, ensures the smooth flow of energy throughout the body, nourishes the tendons and ligaments, manifests in the nails and opens in the eyes. The gallbladder stores bile, which breaks down fats.

□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 (What causes the stress? _____)
□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, Shoulder
□Drink Alcohol (What type? _____, How much per week? _____)
□Recreational Drugs (Which? _____, How much per week? _____)
□Hip Pain
□High Pitched Ringing in the Ears
□Gall Stones (History or Current)
□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:
The following symptoms are indicators of kidney or urinary bladder malfunction. The kidney and adrenal system govern birth/growth/reproduction/development, produce the bone marrow, nourish the brain, control the bones, govern water, open the ears, manifest the hair, and control the ureter/spermatic duct and lower section of the large intestine. The urinary bladder stores and eliminates impure fluids from the body.

□Frequent Cavities
□Easily Broken Bones
□Sore Knees
□Weak Knees
□Cold Sensation 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
□Lack of Bladder Control
□Fear
□Easily Startled

Urination:
□Normal Color
□Dark Yellow
□Clear
□Reddish
□Cloudy
□Scanty
□Profuse
□Strong Odor
□Burning
□Painful
□Discharge
□Difficult
□Painful
□Urgent
□Frequent

Libido:
□Normal
□High
□Low

Women Only:

Regular menstrual cycle? □Y □N Pregnant? □Y □N

Number of children: _____ Number of Pregnancies: _____
Age of first Menstruation: _____ Age of Menopause (if applicable): _____
Average number of days of flow: _____Average number of days of entire cycle: _____
□Vaginal Discharge □Bleeding Between Periods

Do you experience any of the following premenstrual symptoms?

□Nausea □Vomiting □Water Retention □Breast Swelling
□Food Cravings □Headaches □Migraines □Breast Tenderness
□Depression □Irritability □Anxiety □Other Emotions: _____
□Dull Pain, Where? _____ □Sharp Pain, Where? _____

Please fill in the following menstrual chart:

	Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7
Color (normal, brightened, 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:

□Swollen Testes □Testicular Pain □Impotence □Premature Ejaculation
□Feeling of Coldness or Numbness in External Genitalia □Other:_____

MEDICATIONS, VITAMINS AND SUPPLEMENT LOG

Name: _____ Medical/Allergy Alerts: _____

DATE STARTED	MEDICATION/VITAMIN/ SUPPLEMENT	REASON FOR TAKING	DOSAGE	QUANTITY	FREQUENCY

NOTES: _____

_____

_____

DIETARY INTAKE

Please list typical foods eaten for each meal and amount of beverage consumed each day of the following:

Diet:	Beverage/ Day:
Breakfast:	Water:
Lunch:	Soda:
Dinner:	Milk:
Snacks:	Juice:
	Coffee:
	Tea:
	Alcohol: