

# HEALTH HISTORY QUESTIONNAIRE

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. 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 \_\_\_\_\_ Date \_\_\_\_\_

Street \_\_\_\_\_ City \_\_\_\_\_ State/Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ eMail \_\_\_\_\_

Age \_\_\_\_\_ Date of Birth \_\_\_\_\_ Male \_\_\_\_\_ Female \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_

Race:  American Indian or Alaska native     Asian     Black or African American  
 Native Hawaiian or Other Pacific Islander     White

Ethnicity:  Hispanic or Latino     Not Hispanic or Latino

Marital Status:  Married     Never Married     Widowed     Divorced or Separated

Education:  Grammar School     High School     College     Masters     Doctorate

Occupation: \_\_\_\_\_ Retired: \_\_\_\_\_ Disabled: \_\_\_\_\_ Unemployed: \_\_\_\_\_

Family Physician: \_\_\_\_\_ Referred by: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Emergency Contact Relation to you: \_\_\_\_\_

Emergency Contact telephone: \_\_\_\_\_

Have you ever been treated by acupuncture or Oriental medicine before?     Yes     No

Main Problem you would like us to help you with: \_\_\_\_\_

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

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

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**What other kinds of treatment have you tried?**    Western Medicine    Acupuncture  
 Herbs    Massage    Physical Therapy    Chiropractor    Reiki    Homeopathy  
 Other: \_\_\_\_\_

**How confident are you that you can resolve the symptoms of your main complaint with acupuncture and Chinese herbal medicine?**

Not confident    Slightly confident    Moderately confident    Confident    Very confident

**Secondary Complaints you would like us to help you with:** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**Past Personal Medical History of Significant Illnesses:**    Asthma    Allergies    Diabetes

Cancer    Stroke    Heart disease    High Blood Pressure    Seizures    Hepatitis

Rheumatic Fever    Thyroid disease    Venereal disease   Other: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**Hospitalizations/Surgeries (including dates):** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

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

\_\_\_\_\_  
\_\_\_\_\_

**Allergies (drugs, chemicals, metals, foods):** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**Family Medical History:** (check all that are applicable)    Asthma    Allergies    Diabetes

Cancer    Stroke    Heart disease    High Blood Pressure    Seizures    Thyroid

Hepatitis    Rheumatic Fever    Thyroid disease    Venereal disease   Other: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

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

\_\_\_\_\_  
\_\_\_\_\_

**Are there any areas of your life that you find stressful? Please describe:** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**Do you have a regular exercise program?**    No    Yes   If yes, please describe: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Do you follow any type of special diet (e.g. vegetarian, vegan, medical related, or other)?

No  Yes If Yes, what type of diet? \_\_\_\_\_

Describe your average daily diet:

Morning: \_\_\_\_\_

Afternoon: \_\_\_\_\_

Evening: \_\_\_\_\_

Do you smoke?  No  Yes If Yes, how many cigarettes or cigars per day? \_\_\_\_\_

How many cups of caffeinated coffee, tea, or cola do you drink per week? \_\_\_\_\_

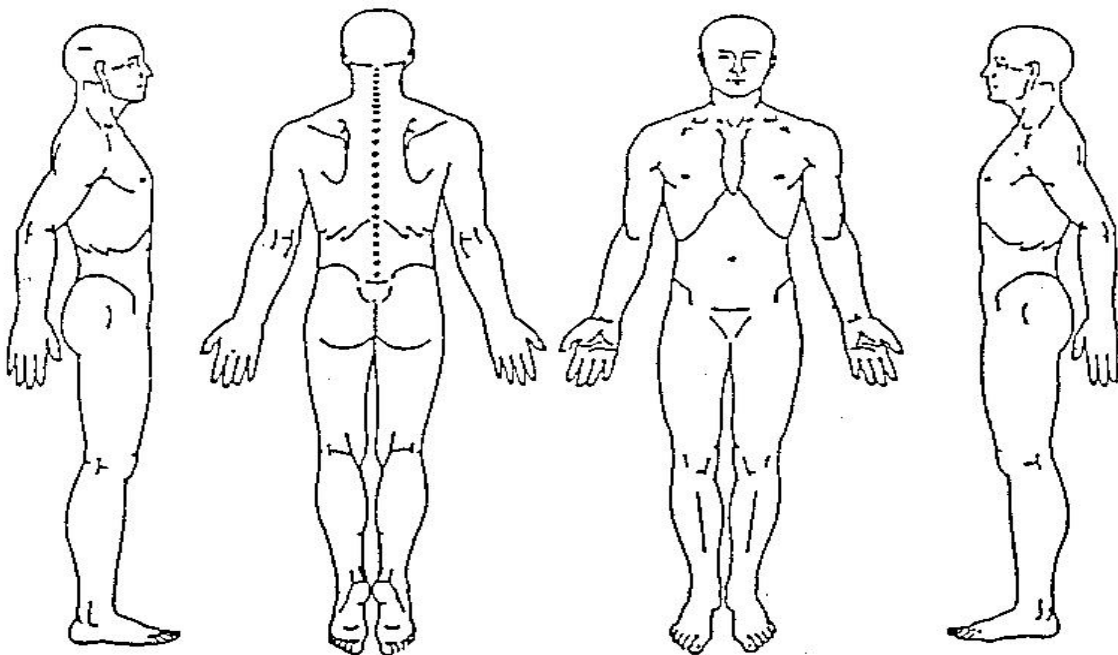
How many 8 oz. glasses of water do you drink per day? \_\_\_\_\_

How many alcoholic beverages do you drink per week? \_\_\_\_\_

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

\_\_\_\_\_

Please indicate any painful or distressed body areas by circling the particular area:



Please check if you have had any of the following, particularly if in the last three months:

**GENERAL:**

- Fevers
- Chills
- Fatigue
- Sweat easily
- Poor sleeping
- Night sweats
- Weight loss
- Cravings
- Weight gain
- Change in appetite
- Strong thirst for:  Hot drinks  Cold drinks
- Sudden energy drop, if so what time of day? \_\_\_\_\_
- Bleed or bruise easily
- Peculiar tastes or smells

**SKIN & HAIR:**

- Rashes
- Ulcerations
- Hives
- Itching
- Eczema
- Pimples
- Dandruff
- Loss of hair
- Recent moles
- Psoriasis
- Dermatitis
- Acne
- Change in hair or skin texture
- Any other skin or hair problems? \_\_\_\_\_

**HEAD, EYES, EARS, NOSE & THROAT:**

- Dizziness
- Concussions
- Migraines
- Glasses
- Eye strain
- Eye pain
- Poor vision
- Night blindness
- Color blindness
- Cataracts
- Blurry vision
- Earaches
- Ringing in ears
- Spots in front of eyes
- Poor hearing
- Sinus problems
- Nose bleeds
- Recurrent sore throats
- Grinding teeth
- Clenching jaw
- Facial pain
- Sores on lips or tongue
- Teeth problems
- Jaw clicks
- Headaches, where and when? \_\_\_\_\_
- Any other head or neck problems? \_\_\_\_\_

**CARDIOVASCULAR:**

- High blood pressure
- Low blood pressure
- Chest pain
- Fainting
- Irregular heart beat
- Difficulty in breathing
- Blood clots
- Phlebitis
- Cold hands or feet
- Swelling of hands
- Swelling of feet
- Varicose or spider veins
- Palpitations
- Palpitations at rest
- Any other heart or blood vessel problems? \_\_\_\_\_

**RESPIRATORY:**

- Cough
- Coughing blood
- Asthma
- Bronchitis
- Pneumonia
- Pain with deep breath
- Chest tightness
- Difficulty breathing when lying down
- Phlegm production, what color? \_\_\_\_\_

**GASTROINTESTINAL:**

- Nausea
- Vomiting
- Diarrhea
- Constipation
- Gas
- Belching
- Black stools
- Blood in stools
- Indigestion
- Bad breath
- Rectal pain
- Hemorrhoids
- Bleeding gums
- Food stagnation
- Bloating/edema
- Acid reflux/GERD
- Hernia
- Excessive appetite
- Poor appetite
- IBS/Crohn's disease
- Colitis
- Slow digestion
- Abdominal pain/cramps
- Chronic laxative use
- Loose stools, more than 2 per day
- Any other problem with Stomach or intestines? \_\_\_\_\_

**GENITO-URINARY:**

- Frequent urination
- Blood in urine
- Pain upon urination
- Urgency to urinate
- Unable to hold urine
- Kidney stones
- Decrease in flow
- Impotency
- Sores on genitals
- Any particular color to your urine? \_\_\_\_\_

- Do you wake up at night to urinate? If yes, how many times a night? \_\_\_\_\_
- Any other problems with your genital or urinary systems? \_\_\_\_\_

**REPRODUCTIVE & GYNECOLOGIC:**

- Are you pregnant?  Yes  No  
 Is it possible that you are pregnant?  Yes  No  
 Number of pregnancies: \_\_\_\_\_ Live Births: \_\_\_\_\_ Miscarriages: \_\_\_\_\_  
 Abortions: \_\_\_\_\_ Premature births: \_\_\_\_\_  
 Age at first menses: \_\_\_\_\_ Time period between menses: \_\_\_\_\_  
 Duration of menses: \_\_\_\_\_ Last PAP: \_\_\_\_\_
- Irregular periods  Painful periods  Clots  Breast lumps
  - Vaginal sores  Vaginal discharge  Vaginal dryness  Endometriosis
  - Uterine fibroids  Polycystic Ovarian disease  Fibrocystic breast tissue
  - Unusual character of blood (heavy, scanty) \_\_\_\_\_
- Do you practice birth control?  Yes  No If yes, what type? \_\_\_\_\_ How long? \_\_\_\_\_

**MUSCULOSKELETAL:**

- Neck pain  Rotator cuff  Knee pain  Foot/ankle pain
- Muscle pain  Muscle spasm  Muscle weakness  Shoulder pain
- Hip pain  Sciatica  Bursitis  Hand/wrist pain
- Carpal tunnel  Sprains/strains  Tendonitis
- Back pain: Low \_\_\_\_\_ Middle \_\_\_\_\_ Upper \_\_\_\_\_
- Soreness/weakness of lower body (back, hip, knee, ankle, foot)

**NEUROLOGICAL & PSYCHOLOGICAL:**

- Seizures  Dizziness  Loss of balance  Areas of numbness
  - Poor memory  Concussion  Poor coordination  Bad temper
  - Anxiety  Depression  Easily susceptible to stress
  - Nervousness  ADD/ADHD  Manic depression
- Have you ever been treated for emotional problems?  Yes  No  
 Have you ever considered or attempted suicide?  Yes  No  
 Any other neurological or psychological problems? \_\_\_\_\_

**COMMENTS:** *Please tell us briefly of any other problems you would like to discuss.*

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**Your Name:**  
(PLEASE PRINT)

[Empty box for name]

**Today's Date:**  
(PLEASE PRINT)

[Empty box for date]

**INSTRUCTIONS:** Choose one or two symptoms (physical or mental) which bother you the most. Write them on the lines. Now consider how bad each symptom is, over the last week, and score it by circling your chosen number.

**SYMPTOM 1:**  
(PLEASE PRINT)

[Lines for writing Symptom 1]

**0**      **1**      **2**      **3**      **4**      **5**      **6**  
As good as it could be      As bad as it could be

**SYMPTOM 2:**  
(PLEASE PRINT)

[Lines for writing Symptom 2]

**0**      **1**      **2**      **3**      **4**      **5**      **6**  
As good as it could be      As bad as it could be

**Now choose one activity (physical, social, or mental) that is important to you, and that your problem makes difficult or prevents you doing. Score how bad it has been in the last week.**

**ACTIVITY:**  
(PLEASE PRINT)

[Lines for writing Activity]

**0**      **1**      **2**      **3**      **4**      **5**      **6**  
As good as it could be      As bad as it could be

**Lastly, how would you rate your general feeling of WELLBEING during the last week?**

**0**      **1**      **2**      **3**      **4**      **5**      **6**  
As good as it could be      As bad as it could be

**How long have you had Symptom 1, either all the time or on and off? (Please circle):**

0 - 4 weeks      4 - 12 weeks      3 months - 1 year      1 - 5 years      over 5 years

**Are you taking any medication for this problem? (Please circle):**

**YES**      **NO**

**If YES:**

**1. Please write in the name of the medication, and how much you take a day or a week:**

[Line for medication name and dosage]

**2. Is cutting down this medication . . . . .**

(Please circle):

Not Important      A bit Important      Very Important      Not Applicable

**If NO:**

**Is avoiding medication for this problem . . . . .**

(Please circle):

Not Important      A bit Important      Very Important      Not Applicable

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CHART-No

DE-by-on: