

# HEALTH HISTORY QUESTIONNAIRE

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:

\_\_\_\_\_

Address:

\_\_\_\_\_

City, State, and Postal Code:

\_\_\_\_\_

Home Phone: (\_\_\_\_) \_\_\_\_\_ Work Phone:

(\_\_\_\_) \_\_\_\_\_

Age: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Place of Birth:

\_\_\_\_\_

Guardian (if under 18):

\_\_\_\_\_

Gender: M F Height: \_\_\_\_' \_\_\_\_" Weight: \_\_\_\_\_ lbs.

Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Driver's License  
Number: \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

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How did you hear about our office? \_\_\_\_\_

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

1. \_\_\_\_\_ 4. \_\_\_\_\_

2. \_\_\_\_\_ 5. \_\_\_\_\_

3. \_\_\_\_\_ Additional: \_\_\_\_\_

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:

<input type="checkbox"/> Diabetes	<input type="checkbox"/> Allergies	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Rheumatic Fever
<input type="checkbox"/> Heart Disease	<input type="checkbox"/> CVA (stroke)	<input type="checkbox"/> Vein condition	<input type="checkbox"/> Thyroid disorder
<input type="checkbox"/> Asthma	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Emphysema
<input type="checkbox"/> Jaundice	<input type="checkbox"/> Gonorrhoea	<input type="checkbox"/> Mumps	<input type="checkbox"/> Bleeding tendency
<input type="checkbox"/> Syphilis	<input type="checkbox"/> Measles	<input type="checkbox"/> Chicken pox	<input type="checkbox"/> Nervous disorder
<input type="checkbox"/> Meningitis	<input type="checkbox"/> HIV	<input type="checkbox"/> Polio	<input type="checkbox"/> Mononucleosis
<input type="checkbox"/> Epilepsy	<input type="checkbox"/> High fever	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Multiple Sclerosis
<input type="checkbox"/> Paralysis	<input type="checkbox"/> Cancer	<input type="checkbox"/> Migraines	<input type="checkbox"/> High blood pressure
<input type="checkbox"/> Other lung illnesses	<input type="checkbox"/> Other liver illnesses	<input type="checkbox"/> Other heart illnesses	<input type="checkbox"/> Other kidney illnesses
<input type="checkbox"/> Other: _____			

Immunizations: \_\_\_\_\_

Surgeries: \_\_\_\_\_

## III. Patient Profile

Please clearly mark any areas of pain and any scars (please indicate which of the areas are scars):

Is the pain:

Sharp                      Burning                      Aching  
Cramping                      Dull                      Moving  
Fixed                      Other: \_\_\_\_\_

Do the following lessen the pain?

Pressure                      Cold                      Heat  
Exercise                      Other: \_\_\_\_\_

Do the following worsen the pain?

Pressure                      Cold  
Heat                      Other: \_\_\_\_\_



Please check the following that currently pertain to you (if you have symptoms in the following categories, it indicates that you have a problem with that organ's function):

Overall Temperature (Kidney function):

- |   |  |
|---|--|
| <input type="checkbox"/> Cold hands                         | <input type="checkbox"/> Cold fingers                      |
| <input type="checkbox"/> Cold feet                          | <input type="checkbox"/> Cold toes                         |
| <input type="checkbox"/> Sweaty hands                       | <input type="checkbox"/> Sweaty feet                       |
| <input type="checkbox"/> Hot body temperature (sensation)   | <input type="checkbox"/> Cold body temperature (sensation) |
| <input type="checkbox"/> Afternoon flushes                  | <input type="checkbox"/> Night sweats                      |
| <input type="checkbox"/> Heat in the hands, feet, and chest | <input type="checkbox"/> Hot flashes any time of the day   |
| <input type="checkbox"/> Thirsty                            | <input type="checkbox"/> Perspire easily                   |
| <input type="checkbox"/> Lack of perspiration               | <input type="checkbox"/> Take water to bed                 |

Overall energy (Lung, Kidney function):

- |  |  |
|--|--|
| <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Difficulty keeping eyes open in the daytime |
| <input type="checkbox"/> General weakness    | <input type="checkbox"/> Easily catch colds                          |
| <input type="checkbox"/> Low energy          | <input type="checkbox"/> Feel worse after exercise                   |

Overall blood (Liver, Spleen, Heart function):

- |                                    |   |
|------------------------------------|---|
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> See floating black spots |
|------------------------------------|---|

Heart function:

- |   |   |
|---|---|
| <input type="checkbox"/> Palpitations                             | <input type="checkbox"/> Anxiety                          |
| <input type="checkbox"/> Sores on the tip of the tongue           | <input type="checkbox"/> Restlessness                     |
| <input type="checkbox"/> Mental confusion                         | <input type="checkbox"/> Chest pain traveling to shoulder |
| <input type="checkbox"/> Frequent dreams                          | <input type="checkbox"/> Wake unrefreshed                 |
| <input type="checkbox"/> Drink coffee (# of cups per week: _____) |   |

Lung function:

- |  |  |
|--|--|
| <input type="checkbox"/> Nasal Discharge (Color: _____)                            | <input type="checkbox"/> Cough                               |
| <input type="checkbox"/> Nose Bleeds   | <input type="checkbox"/> Sinus Congestion                    |
| <input type="checkbox"/> Dry mouth   | <input type="checkbox"/> Dry throat                          |
| <input type="checkbox"/> Dry Nose  | <input type="checkbox"/> Dry Skin                            |
| <input type="checkbox"/> Allergies (To what? _____)                                | <input type="checkbox"/> Alternating fever and chills        |
| <input type="checkbox"/> Sneezing  | <input type="checkbox"/> Headache (Location: _____)          |
| <input type="checkbox"/> Overall achy feeling <input type="checkbox"/> in the body | <input type="checkbox"/> Stiff neck                          |
| <input type="checkbox"/> Stiff shoulders   | <input type="checkbox"/> Sore throat                         |
| <input type="checkbox"/> Difficulty breathing                                      | <input type="checkbox"/> Smoke cigarettes (# per day: _____) |
| <input type="checkbox"/> Sadness   | <input type="checkbox"/> Melancholy                          |

Spleen function:

- |   |  |
|---|--|
| <input type="checkbox"/> Low appetite         | <input type="checkbox"/> Abrupt weight gain  |
| <input type="checkbox"/> Abrupt weight loss   | <input type="checkbox"/> Abdominal bloating  |
| <input type="checkbox"/> Abdominal gas        | <input type="checkbox"/> Gurgling noise in the stomach                               |
| <input type="checkbox"/> Fatigue after eating | <input type="checkbox"/> Prolapsed organs (previously diagnosed, which organ? _____) |
| <input type="checkbox"/> Easily bruised       | <input type="checkbox"/> Hemorrhoids   |
| <input type="checkbox"/> Pensive              | <input type="checkbox"/> Over-thinking   |
| <input type="checkbox"/> Worry                |  |

Spleen, Stomach, Large Intestine, Small Intestine function:

- |  |   |
|--|---|
| <input type="checkbox"/> Loose Stool               | <input type="checkbox"/> Constipated      |
| <input type="checkbox"/> Incomplete                | <input type="checkbox"/> Diarrhea         |
| <input type="checkbox"/> Blood in stools           | <input type="checkbox"/> Mucous in stools |
| <input type="checkbox"/> Undigested food in stools |   |
-

Dampness trapped in the body:

- |   |   |
|---|---|
| <input type="checkbox"/> General sensation of heaviness in the body | <input type="checkbox"/> Mental heaviness |
| <input type="checkbox"/> Mental sluggishness                        | <input type="checkbox"/> Mental fogginess |
| <input type="checkbox"/> Swollen hands                              | <input type="checkbox"/> Swollen feet     |
| <input type="checkbox"/> Swollen joints                             | <input type="checkbox"/> Chest congestion |
| <input type="checkbox"/> Nausea                                     |   |
| <input type="checkbox"/> Snoring                                    |   |

Stomach function:

- |  |   |
|--|---|
| <input type="checkbox"/> Burning sensation after eating    | <input type="checkbox"/> Large appetite       |
| <input type="checkbox"/> Bad breath                        | <input type="checkbox"/> Mouth (canker) sores |
| <input type="checkbox"/> Bleeding, swollen or painful gums | <input type="checkbox"/> Heartburn            |
| <input type="checkbox"/> Acid regurgitation                | <input type="checkbox"/> Ulcer (diagnosed)    |
| <input type="checkbox"/> Belching                          | <input type="checkbox"/> Hiccoughs            |
| <input type="checkbox"/> Stomach pain                      | <input type="checkbox"/> Vomiting             |

Liver, Gall Bladder function:

- |   |   |
|---|---|
| <input type="checkbox"/> Alternating diarrhea and constipation                                | <input type="checkbox"/> Chest pain                       |
| <input type="checkbox"/> Tight sensation in the chest   | <input type="checkbox"/> Bitter taste in the mouth        |
| <input type="checkbox"/> Anger easily   | <input type="checkbox"/> Frustration                      |
| <input type="checkbox"/> Depression   | <input type="checkbox"/> Irritability                     |
| <input type="checkbox"/> Frequently unable to adapt to stress (What causes the stress? _____) |   |
| <input type="checkbox"/> Skin rashes  | <input type="checkbox"/> Headache at the top of the head  |
| <input type="checkbox"/> Tingling sensation   | <input type="checkbox"/> Numbness                         |
| <input type="checkbox"/> Muscle spasms  | <input type="checkbox"/> Muscle twitching                 |
| <input type="checkbox"/> Muscle cramping  | <input type="checkbox"/> Seizures                         |
| <input type="checkbox"/> Convulsions  | <input type="checkbox"/> Lump in the throat               |
| <input type="checkbox"/> Neck tension   | <input type="checkbox"/> Limited Range-of-Motion, Neck    |
| <input type="checkbox"/> Shoulder tension   |   |
| <input type="checkbox"/> Limited Range-of-Motion, Shoulder                                    | <input type="checkbox"/> Drink alcohol                    |
| <input type="checkbox"/> Recreational drugs (Which? _____, How much per week? _____)          | <input type="checkbox"/> Gall stones (history or current) |
| <input type="checkbox"/> High-pitched ringing in the ears                                     |   |
| <input type="checkbox"/> Sexually transmitted disease (Which? _____)                          |   |

Eyes (Liver function):

- |  |   |
|--|---|
| <input type="checkbox"/> Itchy         | <input type="checkbox"/> Bloodshot              |
| <input type="checkbox"/> Hot           | <input type="checkbox"/> Dry                    |
| <input type="checkbox"/> Watery        | <input type="checkbox"/> Gritty                 |
| <input type="checkbox"/> Blurry vision | <input type="checkbox"/> Decreased night vision |
| <input type="checkbox"/> Near-sighted  | <input type="checkbox"/> Far-sighted            |

Kidney, Urinary Bladder function:

- |  |  |
|--|--|
| <input type="checkbox"/> Frequent cavities               | <input type="checkbox"/> Easily broken bones                         |
| <input type="checkbox"/> Sore knees                      | <input type="checkbox"/> Weak knees                                  |
| <input type="checkbox"/> Cold sensation in the knees     | <input type="checkbox"/> Low back pain                               |
| <input type="checkbox"/> Memory problems                 | <input type="checkbox"/> Excessive hair loss                         |
| <input type="checkbox"/> Low-pitched ringing in the ears | <input type="checkbox"/> Kidney stones                               |
| <input type="checkbox"/> Bladder infections              | <input type="checkbox"/> Wake during the night 2x or more to urinate |
| <input type="checkbox"/> Lack of bladder control         | <input type="checkbox"/> Fear  |
| <input type="checkbox"/> Easily startled                 |  |

Urination:

- |                                       |                                      |                                      |                                    |                                 |
|---------------------------------------|--------------------------------------|--------------------------------------|------------------------------------|---------------------------------|
| <input type="checkbox"/> Normal color | <input type="checkbox"/> Dark yellow | <input type="checkbox"/> Clear       | <input type="checkbox"/> Reddish   | <input type="checkbox"/> Cloudy |
| <input type="checkbox"/> Scanty       | <input type="checkbox"/> Profuse     | <input type="checkbox"/> Strong odor |                                    |                                 |
| <input type="checkbox"/> Burning      | <input type="checkbox"/> Painful     | <input type="checkbox"/> Discharge   | <input type="checkbox"/> Difficult | <input type="checkbox"/> Urgent |
| <input type="checkbox"/> Frequent     |                                      |                                      |                                    |                                 |

- Libido:                      Normal                      High                      Low
-

**Women only:**

Pregnant?  Y  N      Regular menstrual cycle?  Y  N      Date of most recent cycle \_\_\_\_\_  
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 pre-menstrual syndromes?

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, bright 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 \_\_\_\_\_

**All please fill out:**

Other Comments:

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Patient Signature: \_\_\_\_\_

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