Health History Questionnaire

Please complete this form as thoroughly as possible. Additional information or questions may be noted in the comment section. All information will be held in confidence within the limits of the law.

Name_____ Date____/____/_____
Address _____
City _____ State_____ Zip_____
Phone Numbers_____
Date of Birth _____/_____/_____
Occupation _____
Marital status single__ married__ divorced__ widowed__ Children?_____
Have you previously had acupuncture? Y N
How did you learn about our services?_____
How would you like to receive appointment reminders?
___text(provide number) ___email(provide address on last page) ___cell phone(provide number)

Please list conditions for which you are seeking treatment:

_____

_____

Pain (please skip this section if your condition does not involve pain)
Circle the number that best describes your level of pain: 0 1 2 3 4 5 6 7 8 9 10
Circle the frequency of your pain: *intermittent frequent occasional constant*
Circle the characteristic of your pain: *sharp stabbing dull achy radiating burning*
Is there any time of day in which pain is worse? *morning afternoon night*
Is there anything that alleviates pain? Y N _____
Is there anything that aggravates pain? Y N _____

Medical History (circle all that apply)
Diabetes Hypertension Cancer Stroke Vascular disease Heart Attack Arrhythmia Pacemaker
Elevated Cholesterol Kidney disease Pulmonary disease Pneumonia Asthma
Multiple Sclerosis Parkinson Seizures Migraines Shingles Gallbladder/Liver
Gastric Ulcer Crohn's disease/Ulcerative Colitis Irritable Bowel Syndrome Diverticulosis
Colon polyps Hemorrhoids Anemia Gum disease
Hepatitis TB HIV/Aids Chronic Fatigue Syndrome Rheumatoid Arthritis Lupus
Autoimmune disease
Osteoarthritis Osteoporosis/Osteopenia Fractures Low back pain Sciatica Fibromyalgia
Uterine Fibroids Infertility Gynecologic disorder Urologic disorder Thyroid disorder
Drug/Alcohol problem Depression Anxiety Allergies Sinus infections Eczema Psoriasis
*Acne Other*_____

Past surgeries, major illnesses, hospitalizations and trauma:

_____

_____

_____

Medications/Supplements: list any medications and supplements you are taking

_____

_____

_____

Sleep:
What time do you typically go to bed?____ What time do you most often awaken?____
Do you have trouble getting out of bed in the morning? Y N
Do you feel rested upon awakening? Y N
Do you depend upon caffeine to help you wake up in the morning? Y N
Do you have trouble falling asleep or staying asleep? Y N If so, what hours?_____
Do you ever take something to help you get to sleep? Y N
Do you ever get hot at night or sweat? Y N
Do you dream? Y N If so, are your dreams frequent and vivid ? Y N

Bowel habits:
How many times a day do you typically have a bowel movement (BM)? ____
Any problems with constipation or diarrhea? Y N
Do you ever have to strain to move your bowels? Y N
Are your bowel movements ever painful? Y N
Have you ever noticed blood in your stool? Y N
Please circle the words that best describe the color of your bowel movements
light brown medium brown dark brown brownish-black greenish-black other
Please circle the words that best describe the consistency of your BM
Liquid semi-liquid formed and loose soft and formed moderately hard very hard
Please circle the words that best describe the size of your BM
Liquid/unformed soft/unformed (mush) large formed thin formed small round other
Do your BM's or gas have a strong odor? Y N

Digestion: (circle any that apply)
nausea vomiting excessive appetite frequent gas bloating belching
heartburn abdominal pain loss of appetite stomach pain relieved by eating
certain foods usually aggravate my digestion excessive hunger pain

Urination: (circle any that apply)
urgency painful burning difficulty initiating
clear light yellow dark yellow amber bright yellow (from vitamins)
How many times a day do you typically urinate during the day? 1-3x 4-6x 7+
How many times do you typically urinate during the night? 0 1-2x 3or more

Energy: (circle all answers that best describes your level of energy)
chronically fatigued - tire easily - fair energy - high energy most always
tired in the mornings- tired in the afternoon- use coffee/food/ stimulant to perk energy
get along okay, but would like to have more energy - get sleepy after eating

Mental/emotional (circle all that apply)
I'm in a good mood most days - my moods fluctuate- I am frequently depressed
I get anxious easily- I have a tendency to be irritable- I get upset easily
I am often sad- I'm easy going- I often cry- I sometimes cry- I rarely cry
I laugh often- I laugh sometimes- I rarely laugh- My memory is poor
My memory is good in some ways and bad in others-I get easily confused

Immunity:
Do you frequently catch colds and/or flu? *never rarely occasionally frequently*
Do you ever get cold sores/fever blisters? *never rarely occasionally frequently*
Do you have any allergies? Y N *seasonal animals dust food medication other*
How often do you have sinus infections? *never rarely occasionally frequently*

Neurologic: (circle all that apply)
dizziness numbness/tingling seizures poor balance tension headaches migraines ringing in the ears

Female Reproductive:
Do you currently have periods? Y N If so, is your cycle regular? Y N
If not, at what age did your periods cease? _____
Are/were your periods ever painful? Y N
How many days do they/did they typically last? _____
What is/was the typical flow? *light medium heavy for a day or two excessive*
What color best describes your menstrual blood?
brown brownish red dark red purple/red bright red
Do/did you ever notice clots? Y N If so, please circle the typical size
*Pea-size dime-size grape-size other*_____
Any pre-menstrual symptoms presently or in the past?
Irritability/moodiness sadness breast tenderness abdominal cramping headache other
Have you ever experienced Hot flashes in the past? Y N Presently? Y N
Any vaginal discharge? Y N (if so, please describe)_____
How many times have you been pregnant? _____
Circle any problems experienced during pregnancy, delivery or after birth *nausea/vomiting excessive weight gain water retention difficult labor and/or delivery post-partum depression other*
Any problems with low libido? Y N
Do you currently take any type of Hormone replacement? Y N _____

Male Reproductive: (circle all that apply)
prostate problems erectile dysfunction testicular pain/swelling penile discharge

Skin: (circle all that apply)
oily skin dry skin rashes eczema acne hives sores/wounds

Lifestyle:
Do you exercise regularly? Y N How many times per week? _____
Have you ever smoked or used other tobacco product? Y N If so, how many packs/day?___
Have you ever used recreational drugs? Y N
Do you ever drink alcoholic beverages? Y N If so, what type and how often?

_____

Diet:
What type and amount of beverages do you typically consume in a day?

_____

_____

Are you frequently thirsty? Y N

Please describe your typical meals:

Breakfast_____

_____

Lunch_____

_____

Dinner_____

_____

Snacks_____

_____

Do you have cravings for certain foods e.g., sweets, salty foods, etc.? _____

_____

Do you ever binge or eat for comfort? Y N
Is there any time of day in which you tend to binge or eat more?_____
Are you willing to make changes in your diet to maximize your health? Y N
Would you like to receive monthly newsletters about acupuncture via email? Y N If so, please provide your email address: _____

Additional
Comments_____

_____

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