



ACUHEALTH

Health History Questionnaire

Date / /

Please help me provide you 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 any questions, please ask. If there is anything you wish to bring to my attention that is not included in this form please note it in the comments section on the last page. Thank you.

Personal Information

| | | | |
|---|-------------------------|---|-----------|
| Name: | | Social Security Number (optional) | |
| Address: | City: | State: | Zip Code: |
| Home Phone () | Work Phone: () Ext. | Cell Phone: () | Age: |
| Date of Birth: / / | City and State of Birth | Sex: Male ___ Female ___ | |
| Height: | Weight: | Marital Status: | |
| Occupation: | Employer Name: | Family Physician: | |
| Referred By: | Emergency Contact: | Emergency Contact Phone: () | |
| e-mail address | | | |
| Where may we contact you? Home / Work / Cell What is the best time to reach you? | | Have you ever been treated with acupuncture or oriental medicine before? | |

What's Bothering You?

What is/are the main problem(s) you would like me to help you with?

How long ago did this problem begin (be specific):

To what extent does this problem interfere with your daily activities (work, sleep, sex etc.)? :

Have you been given a diagnosis for this problem? If so, what:?

What other kinds of treatment have you tried?



Medical History

Please indicate date of disease

| | | | |
|------------------|---------------------|-----------------|-----------------|
| Cancer | High Blood Pressure | Thyroid Disease | Diabetes |
| Heart Disease | Seizures | Hepatitis | Rheumatic Fever |
| Venereal Disease | Other | | |

Surgeries (type and date):

Significant Trauma (auto accidents, falls etc.):

Significant Dental Work (type and date):

Birth History (prolonged labor, forceps delivery, etc.):

Allergies (drugs, chemicals and foods. Type of reaction):

Family Medical History: Put an "x" next to all that apply

| | | | |
|----------|---------------------|----------|-----------|
| Diabetes | High Blood Pressure | Stroke | Asthma |
| Cancer | Heart Disease | Seizures | Allergies |
| Other: | | | |

Medicines taken within the last two months (including: vitamins, drugs, herbal remedies etc.):

Occupational Stress (physical, psychological, chemical etc.)

Other Stress: (Family/Home/Relationships)

Do you have a regular exercise program? Yes or No Please describe:

Have you ever been on a restricted diet? Yes or No What kind?



Medical History Cont'd

Please put an "x" next to all symptoms you have had in the last 6 months.

General:

- Chills
- Fevers
- Sweat easily
- Night sweats
- Localized weakness
- Bleed or bruise easily
- Peculiar tastes or smells
- Thirst for cold drinks
- Thirst for warm drinks

Head, Eyes, Ears, Nose and Throat:

- Dizziness
- Migraines
- Headaches
 - When:
 - Where:
- Facial Pain
- Glasses
- Poor vision
- Night blindness
- Blurry vision
- Color blindness
- Blind field
- Spots in front of eyes
- Eye pain
- Eye strain
- Excessive tearing
- Discharge from eyes
- Poor hearing
- Ringing in ears
- Earaches
- Discharge from ear
- Nose bleeds
- Sinus congestion
- Nasal drainage
- Grinding teeth
- Jaw clicking
- Concussions
- Recurrent sore throat
- Hoarseness
- Sores on lips or tongue
- Other head or neck problems:

Skin and Hair:

- Rashes
- Itching
- Hives
- Change in hair of skin
- Ulceration's
- Eczema
- Oozing skin lesion
- Pimples
- Recent moles
- Change in shape or coloration of moles
- Loss of hair
- Dandruff

Respiratory:

- Cough
- Asthma / wheezing
- Pain with a deep breath
- Difficulty breathing when lying down
- Production of phlegm
 - What color?
- Coughing blood
- Pneumonia
- Bronchitis
- Other lung problems:

Cardiovascular:

- High Blood Pressure
- Low Blood Pressure
- Chest discomfort / pain
- Heart palpitations
- Cold hands or feet
- Swelling of hands
- Swelling of feet
- Blood clots
- Fainting
- Difficulty breathing
- Other heart or blood vessel problems:



Medical History Cont'd

Gastrointestinal:

- Bad breath
- Nausea
- Vomiting
- Heartburn
- Belching
- Indigestion
- Diarrhea
- Constipation\Chronic laxative use
- Blood in stools
- Black stools
- Abdominal pain or cramps
- Gas
- Rectal pain
- Hemorrhoids
- Other stomach or intestinal problems:

Genital-Urinary:

- Pain when urinating
- Urgency to urinate
- Frequent urination
- Blood in urine
- Decrease in flow
- Unable to hold urine
- Dribbling
- Kidney stones
- Impotency
- Change in sex drive
- Sores on genitals
- Do you wake up to urinate? Y or N
- If yes, how often?
- What time of night?
- Any particular color to your urine?
- Other genital or urinary system problems:

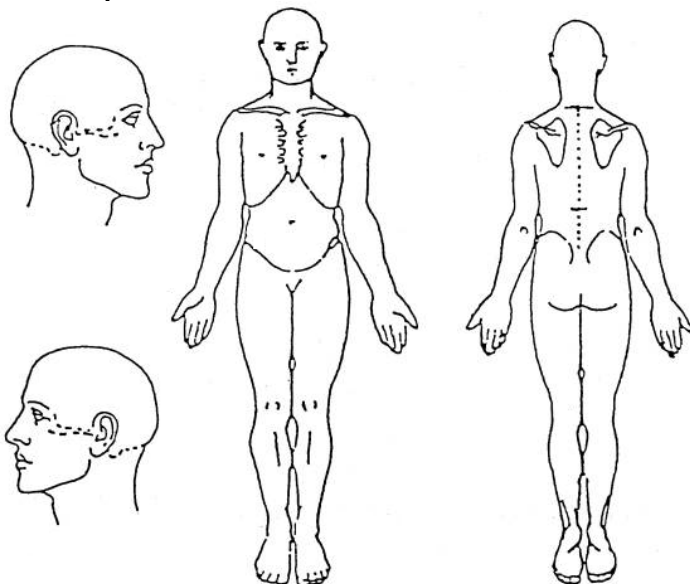
Musculoskeletal:

- Neck pain
- Shoulder pain
- Back pain
- Elbow pain
- Hand / wrist pain
- Hip pain
- Knee pain
- Foot / ankle pain
- Muscle pain
- Muscle weakness

Neuro-psychological

- Seizures
- Areas of numbness
- Weakness
- Sleep disorder
- Concussion
- Bad temper
- Loss of control / violence potential
- Vertigo
- Lack of coordination
- Depression
- Easily susceptible to stress
- Loss of balance
- Poor memory
- Anxiety
- Substance abuse
- Have you ever been treated for emotional problems?
- Have you ever considered suicide?
- Have you ever attempted suicide?

Indicate painful or distressed areas:



AcuHealth Holistic Solutions

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Medical History Cont'd

On a scale of 0 to 10 (no problem to excruciating), please rate the degree of severity of your main complaint now:

On a scale of 0 to 10, please rate the greatest degree of severity of your problem within the last week:

WOMEN ONLY:

Regular menstrual cycle? Y or N

Pregnant? Y or 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? Y or N

Bleeding between periods? Y or N

Do you experience any of the following pre-menstrual syndromes? Put an "x" next to all that apply.

| | | | |
|------------------|-------------------|-----------------|-------------------|
| Nausea | Vomiting | Water retention | Breast swelling |
| Food cravings | Headaches | Migranes | Breast tenderness |
| Depression | Irritability | Anxiety | |
| Dull pain? Where | Sharp pain? Where | | |
| Other emotions | | | |

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

Do you experience any of the following symptoms? Put an "x" next to all that apply.

| | | | |
|---|-----------------|-----------|-----------------------|
| Swollen testes | Testicular pain | Impotence | Premature ejaculation |
| Feeling of coldness or numbness in external genitalia | | Other | |

Other Comments:

Thank you. Please print this document and bring to your appointment

Patient Signature: _____

Acupuncturist Signature: _____