Patient:_____ Date:_____

ACUPUNCTURE HEALTH HISTORY QUESTIONAIRE

Patient Confidential Information

Please fill out this questionnaire to the best of your ability. Your answers will assist us in providing you with a complete evaluation. All answers will be held in absolute confidentiality. If you have any questions, please ask. If there is anything you wish to add that is not included in this questionnaire, please note it in the "Comments" section at the end. Thank you.

Name_____Date_____

Address_____City_____State/Zip_____

Home Phone_____Work Phone_____Cell Phone_____

Email_____Social Security #:_____

Age_____Date of Birth_____ Male____ Female____ Marital Status: _____

United Healthcare member # (if applicable) :_____

Occupation: _____ Employer:_____

Employer's Address: _____City _____State/Zip_____

Language spoken at home:_____

Emergency Contact: _____Relation to You_____

Emergency Contact telephone:_____

CASE HISTORY

Chief Complaint: _____

_____

Complaint result of (circle): Auto Accident Injury Job Related Other

Date of accident/injury/other: ____/_____/_____

Have you seen any other doctor about this condition? _____if yes, when? _____

Do you experience pain? Y or N Pain scale of 1-10 with 1 being the least painful: _____

Doctor's Name: _____ Address: _____

How has this condition affected your life? _____

_____

Have you sought any other help for this condition? Whom and when?_____

Patient:_____ Date:_____

Is there anything else that you would like us to help you with?_____

_____

_____

_____

Past Personal Medical History of Significant Illness (please circle all that apply):

☐ Asthma ☐ Allergies ☐ Hepatitis ☐ Tuberculosis Autoimmune

☐ Diabetes ☐ Cancer ☐ Stroke ☐ Heart disease ☐ High Blood Pressure

☐ Seizures ☐ Thyroid ☐ Clotting disorders ☐ Other:_____

Hospitalizations/Surgeries (include dates):_____

_____

Significant Trauma (accidents, falls, head injuries etc., including dates)_____

_____

Allergies (environmental, seasonal, chemical, mediation):_____

_____

Medications:

Name	Dosage	Length of time taken	Reason for taking

What areas of your life are stressful? How does it affect your quality of life?_____

_____

_____

Patient:_____ Date:_____

Do you have a regular exercise program? ☐ No ☐ Yes If yes, please describe:_____

_____

_____

Do you follow any type of special diet (i.e., vegetarian, vegan, medically related, or other)?_____

_____

_____

Do you smoke? _____How much/day_____How long?_____

How many cups of caffeinated coffee, tea, or soda do you drink per week? Please list separately

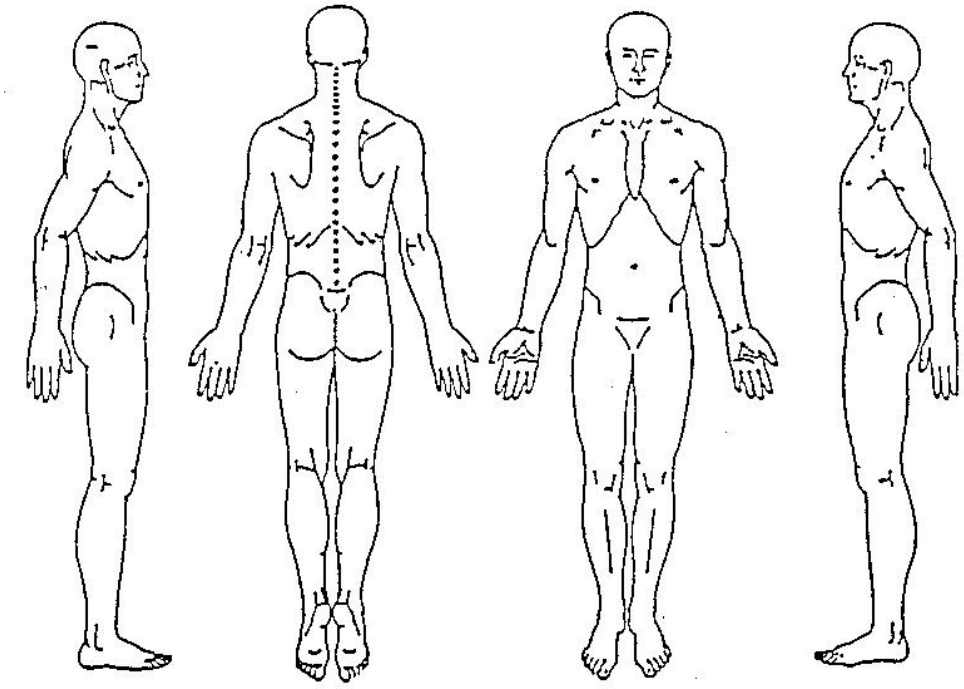
_____

_____

How many glass of 8 oz. water do you drink per day?_____

How many alcoholic beverages do you drink per week?_____

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



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

GENERAL:

Patient:_____ Date:_____

□ Fevers □ Chills □ Fatigue □ Sweat easily or profusely

□ Poor sleeping □ Night sweats □ Unexplained weight loss or weight gain

□ Cravings □ Change in appetite □ Strong thirst for: □ hot drinks □ cold drinks

□ Sudden drop in energy, if so what time of day?_____

□ Bleed or bruise easily □ Peculiar tastes or smells □ Lack of taste or smell

SKIN & HAIR (please circle all that apply)**:**

□ Rashes □ Ulcerations □ Hives □ Itching – night or day

□ Eczema □ Pimples □ Dandruff □ Loss of hair

□ Recent moles □ Psoriasis □ Dermatitis □ Acne

□ Change in hair or skin texture Rosacea

Any other skin or hair problems of concern?_____

_____

HEAD, EYES, EARS, NOSE & THROAT (please circle all that apply)**:**

□ Dizziness	Concussions □	Migraines	Glasses
□ Eye strain	Eye Pain	Poor Vision □	Night blindness
□ Blurry vision □	Earaches	Ringing in ears □	Poor hearing
□ Spots in field of vision		Nose bleeds	Grinding teeth
□ Sinus problems	Recurrent sore throats		Facial pain
□ Sores on lips or tongue		Teeth problems □	Jaw clicks

□ Headaches, where and when?_____

_____

□ Any other head or neck problems? _____

_____

_____

CARDIOVASCULAR (please circle all that apply)**:**

□High/Low Blood pressure	□Chest pain □	Fainting
□ Irregular heart beat	□ Difficulty breathing	□ Blood clots □
□ Cold hands or feet	□ Swelling of hands	□ Swelling of feet
□ Varicose or spider veins	□ Shortness of breath	Palpitations at rest

□ Any other heart or blood vessel problems?_____

_____

Patient:_____ Date:_____

RESPIRATORY (please circle all that apply)**:**

□ Cough □ Coughing blood □ Asthmas □ Bronchitis

□ Pneumonia □ Pain w/deep breath □ Chest tightness

□ Difficulty breathing when lying down

□ Phlegm production: □ nose / throat, what color?_____

GASTROINTESTINAL (please circle all that apply)**:**

Nausea □	Vomiting	Diarrhea	Constipation
Gas □	Belching	Black Stools □	Blood in stools
Indigestion □	Bad Breath	Rectal Pain	Hemorrhoids
Bleeding gums	Bloating/edema	Acid reflux/GERD	Hernia
Excessive appetite	Poor appetite □	IBS/Chrohn's Disease	Colitis
Slow digestion □	Abdominal pain/cramps		

Loose stools, more than 2 per day

Any other problem with stomach or intestines_____

GENITO-URINARY (please circle all that apply)**:**

□ 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?_____

MALE:

Genital Itching _____ □ Genital Pain, where & when?_____

Erection difficulties _____ Incontinence _____

Do you practice birth control?_____

FEMALE:

Are you pregnant? □ Yes □ No

Is it possible that you pregnant? □ Yes □ No

Patient:_____ Date:_____

Number of pregnancies:_____ Live Births:_____ Miscarriages:_____

Abortions:_____ Premature births:_____

Age at first menses:_____Time period between menses:_____Date of Last Period: _____

Duration of menses:_____ Last PAP:_____

□ Irregular Periods □ Pain periods □Clots □ Breast lumps

□ Vaginal sores □ Vaginal Discharge □ Vaginal dryness □ Uterine Fibroids

□ Unusual character of blood (heavy, scanty)_____

□ Endometriosis □ 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 (please circle all that apply):

□ 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 & PHYCHOLOGICAL (please circle all that apply)**:**

□ 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 issues?_____

_____

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

_____

_____

Patient:_____ Date:_____

_____

_____

_____

_____

_____