PLEASE PUT A CHECK NEXT TO ANY CONDITIONS YOU HAVE EXPERIENCED WITHIN THE LAST THREE MONTHS. INDICATE THE LENGTH OF TIME YOU HAVE HAD THIS CONDITION.

GENERAL

☐ Poor appetite	☐ Weight gain	☐ Night sweats
☐ Insomnia	☐ Weight loss	☐ Fever
☐ Disturbed sleep	☐ Changes in appetite	☐ Chills
☐ Localized weakness	☐ Sweating easily	☐ Sudden energy drop (time of day?)
☐ Cravings	☐ Tremors	
☐ Strong thirst	☐ Bleeding or bruising easily	☐ Poor balance

Other unusual or abnormal conditions you have noticed in your general sense of health

SKIN AND HAIR

☐ Rashes	☐ Eczema	☐ Recent moles
☐ Ulcerations	☐ Pimples	☐ Changes in texture of hair or skin
☐ Hives	☐ Dandruff	
☐ Itching	☐ Hair loss	

Any other hair or skin problems

HEAD, EYES, EARS, NOSE, THROAT

☐ Dizziness	☐ Color blindness	☐ Recurrent sore throats
☐ Concussions	☐ Cataracts	☐ Nose bleeds
☐ Migraines	☐ Blurry vision	☐ Grinding teeth
☐ Glasses	☐ Earaches	☐ Sores on lips or tongue
☐ Spots in front of eyes	☐ Ringing in ears	☐ Facial pain
☐ Eye pain	☐ Poor hearing	☐ Teeth problems
☐ Poor vision	☐ Eye strain	☐ Headaches (where? when?)
☐ Night blindness	☐ Sinus problems	☐ Jaw clicks

Any other head or neck problems

CARDIOVASCULAR

☐ Dizziness	☐ High blood pressure	☐ Swelling of feet
☐ Low blood pressure	☐ Fainting	☐ Blood clots
☐ Chest pain	☐ Cold hands or feet	☐ Difficulty in breathing
☐ Irregular heartbeat	☐ Swelling of hands	☐ Phlebitis

Any other heart or blood vessel problems

RESPIRATORY

☐ Cough	☐ Bronchitis	☐ Difficulty breathing when lying down
☐ Coughing up blood	☐ Pain with deep inhalation	
☐ Asthma	☐ Pneumonia	☐ Excessive phlegm (color?)

Any other lung problems

HEALTH HISTORY QUESTIONNAIRE FOR PATIENTS

Welcome to our clinic! Please help us provide you with a complete evaluation by taking the time to fill out this questionnaire carefully. All your answers will be held absolutely confidential. If you have questions, please ask us. If there is anything you wish to bring to our attention which is not asked in this form, please note it tin the COMMENTS section. Thank you!

Name:

Street: City State Zip

Age: Height: Weight:

Home Phone: Work Phone:

Date/Place of Birth: Social Security Number:

Occupation: Marital Status:

In Emergency Notify:

Referred by:

Family Physician:

Insurance Carrier: Policy Number:

Have you tried acupuncture or Chinese herbal medicine before?

MAIN PROBLEM(S) YOU WOULD LIKE TO ADDRESS

To what extent does this problem affect your daily activities (work, sleep, eating, etc.)?

How long has it been since you first noticed any symptoms?

Have you been given a diagnosis for the problem by your family physician?

If so, what is it?

What kinds of treatment or therapy have you tried?

PAST MEDICAL HISTORY (PLEASE INCLUDE DATES)

☐ Allergies:	☐ Rheumatic fever	☐ Other significant illness (describe)
☐ Cancer	☐ Surgeries	
☐ Diabetes	☐ Venereal disease	
☐ Hepatitis	☐ Thyroid disease	
☐ High blood pressure	☐ Birth trauma (prolonged labor, forceps delivery, etc)	☐ Accidents or significant trauma (describe)
☐ Heart disease		
☐ Seizures		

OTHER RELEVANT MEDICAL HISTORY

GASTROINTESTINAL

☐ Nausea ☐ Belching ☐ Rectal pain
☐ Vomiting ☐ Black stools ☐ Hemerroids
☐ Diarrhea ☐ Blood in stools ☐ Abdominal pain or cramps
☐ Constipation ☐ Indigestion ☐ Chronic laxative use
☐ Gas ☐ Bad breath

Any other problems with stomach or intestines

GENITOURINARY

☐ Pain on urination ☐ Urgency to urinate ☐ Decrease in flow
☐ Frequent urination ☐ Unable to hold urine ☐ Impotence
☐ Blood in urine ☐ Kidney stones ☐ Sores on genitals

Do you wake up at night to urinate? If so, how often?

Any particular color to your urine?

Any other genital or urinary problems

REPRODUCTIVE AND GYNECOLOGIC

☐ Premenstrual changes ☐ Heavy menstrual flow ☐ Premature births
☐ Menstrual clots ☐ Light menstrual flow ☐ Miscarriages
☐ Painful menses ☐ Irregular menses ☐ Abortions
☐ Unusual menses ☐ Other problems

Age at first menses Age at menopause Number of pregnancies

Time between cycles Duration of bleeding First day of last menses

Do you practice birth control? If so, what type? For how long?

Any other gynecologic problems

MUSCULOSKELETAL

☐ Neck pain ☐ Back pain ☐ Hand/wrist pains
☐ Muscle pains ☐ Muscle weakness ☐ Shoulder pains
☐ Knee pain ☐ Foot/ankle pains ☐ Hip pain

Any other joint or bone problems

NEUROPSYCHOLOGICAL

☐ Seizures ☐ Poor memory ☐ Anxiety
☐ Dizziness ☐ Lack of coordination ☐ Bad temper
☐ Loss of balance ☐ Concussion ☐ Easily susceptible to stress
☐ Areas of numbness ☐ Depression

Have you ever been treated for emotional problems?

Have you ever considered or attempted suicide?

Any other neurological or psychological problems

COMMENTS

Please list any other problems you would like to discuss:

FAMILY MEDICAL HISTORY

☐ Allergies ☐ Cancer ☐ Seizures
☐ Diabetes ☐ Heart disease ☐ Stroke
☐ Asthma ☐ High blood pressure ☐ Other

OCCUPATION

Occupational stress factors (physical, psychological, chemical):

LIFESTYLE

Do you follow a regular exercise program? If so, please describe:

Please describe your average daily diet:

Please check any of the following habits that apply. How much and how often do you use them?

☐ Cigarette smoking ☐ Coffee, tea or cola ☐ Alcoholic beverages

List medications taken within the last two months (vitamins, drugs, herbs, etc.):

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

PLEASE MARK PAINFUL OR DISTRESSED AREAS ON THE CHARTS BELOW

Symbol	Reaction
Pain on pressure	
x	little
xx	moderate
xxx	strong
Swelling	
^	slight
^^	moderate
^^^	severe
Tension/weakness	
≈	weak
#	tense
Spontaneous pain	
†	slight
††	moderate
†††	severe
Pulsing	
o	slight
oo	moderate
ooo	strong
Temperature	
–	colder
+	hotter
Physical	
Ø	sores
*	rashes
« »	spasms