AcuHealing Center

HEALTH HISTORY QUESTIONNAIRE

Your answers are held absolutely confidential! Date_____

Name_____ Home Phone_____

Address_____ Work Phone_____

City_____ State/Zip_____ Cell Phone_____

eMail _____ Age_____ Date of Birth _____

M/F_____ Height_____ Weight_____

Occupation:_____

Family Physician: _____ Referred here by:_____

Emergency Contact:_____Relation to you:_____ Telephone:_____

Have you ever been treated by acupuncture or Oriental medicine before? □ Yes □ No

Main Problem you would like us to help you with:_____

_____

_____

How long ago did this problem begin? _____

Have you been given a medical diagnosis for this problem?_____

What other kinds of treatment have you tried for this problem?_____

_____

Past **PERSONAL** Medical History: □ Asthma □ Allergies □ Diabetes □ Cancer □ Stroke

□ Heart disease □ High Blood Pressure □ Seizures □ Hepatitis □ Thyroid disease

Other:_____

Hospitalizations/Surgeries (including dates):_____

_____

Significant Trauma (auto accidents, falls, etc.):_____

_____

Allergies (medicines, chemicals, metals, foods):_____

Past **FAMILY** Medical History: □ Asthma □ Allergies □ Diabetes □ Cancer □ Stroke

□ Heart disease □ High Blood Pressure □ Seizures □ Hepatitis □ Thyroid disease

Other:_____

Medications taken within the last two months (vitamins, drugs, herbs, etc.):_____

_____

_____

Are there any areas of your life that you find stressful? Please describe:_____

_____

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

_____

Do you follow any type of special diet (e.g. vegetarian, vegan, medical related, or other)? □ No □ Yes If Yes, what type of diet?_____

Do you smoke? □ No □ Yes If Yes, how many cigarettes or cigars per day? _____

How many cups of caffeinated coffee, tea, or cola do you drink per week?_____

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

How many alcoholic beverages do you drink per week?_____

Please describe any use of recreational drug:_____

Please check if you have had any of the following, particularly if in the **past three months**:

GENERAL: □ Fevers □ Chills □ Fatigue □ Sweating easily □ Poor sleeping □ Night sweats □ Weight loss □ Cravings □ Weight gain □ Change in appetite □ Thirst for: □ Hot □ Cold □ Sudden energy drop, if so what time of day?_____

□ Bleed or bruise easily □ Peculiar tastes or smells

SKIN & HAIR: □ Rashes □ Ulcerations □ Hives □ Itching □ Eczema □ Dandruff □ Psoriasis □ Loss of hair □ Dermatitis □ Acne □ Change in hair or skin texture □ Other:_____

HEAD, EYES, EARS, NOSE & THROAT: □ Dizziness □ Concussions □ Migraines □ Glasses □ Eye strain □ Eye pain □ Poor vision □ Night blindness □ Cataracts □ Blurry vision □ Spots in front of eyes □ Earaches □ Ringing in ears □ Poor hearing □ Sinus problems □ Nose bleeds □ Sore throats □ Grinding teeth □ Clenching jaw □ Facial pain □ Sores on lips or tongue □ Teeth problems □ Headaches, where and when?_____

□ Other head or neck problems?_____

CARDIOVASCULAR: □ High blood pressure □ Low blood pressure □ Chest pain □ Fainting □ Irregular heart beat □ Difficulty in breathing □ Blood clots □ Cold hands or feet □ Swelling of hands □ Swelling of feet □ Varicose or spider veins □ Palpitations □ Palpitations at rest □ Any other heart of blood vessel problems?_____

RESPIRATORY: □ Cough □ Coughing blood □ Asthma □ Bronchitis □ Pneumonia □ Pain with deep breath □ Chest tightness □ Difficulty breathing when lying down □ Phlegm/color_____

GASTROINTESTINAL: □ Nausea □ Vomiting □ Diarrhea □ Constipation □ Gas □ Belching □ Black stools □ Blood in stools □ Indigestion □ Bad breath □ Rectal pain □ Hemorrhoids □ Bleeding gums □ Food stagnation □ Bloating/edema □ Acid reflux/GERD □ Hernia □ Excessive appetite □ Poor appetite □ IBS/Crohn's disease □ Colitis □ Slow digestion □ Abdominal pain/cramps □ Chronic laxative use □ Loose stools, more than 2 per day □ Any other problem with Stomach or intestines_____

GENITO-URINARY: □ Frequent urination □ Pain upon urination □ Urgency to urinate □ Unable to hold urine □ Kidney stones □ Blood in urine □ Decrease in urine flow □ Impotency □ Sores on genitals □ Color to your urine? _____ □ Do you wake up at night to urinate? If yes, how many times a night? _____ □ Other problems with your urinary systems?_____

REPRODUCTIVE & GYNECOLOGIC (WOMEN only):

□ Pregnant now □ Is it possible that you are pregnant? □ # of pregnancies: _____ Live Births: _____ Miscarriages: _____ Abortions:_____ □ Age at first menstrual period: _____ Time period between periods:_____ Duration of periods:_____ □ Irregular periods □ Painful periods □ Clots □ Unusual character of blood (heavy, scanty)_____ _____ □ Breast lumps □ Vaginal sores □ Vaginal discharge □ Vaginal dryness □ Endometriosis □ Uterine fibroids □ Polycystic Ovarian Disease □ Fibrocystic breast tissue Do you practice birth control? □ Yes □ No If yes, what type? _____ How long?_____

MUSCULOSKELETAL: □ Neck pain □ Rotator cuff problem □ Knee pain □ Foot/ankle pain pain □ Muscle pain □ Muscle spasm □ Muscle weakness □ Shoulder pain □ Hip pain □ Sciatica □ Bursitis – location_____ □ Hand/wrist pain □ Carpal Tunnel Syndrome □ Sprains/strain – location_____ □ Tendonitis □ Back pain: Low_____ Middle_____ Upper_____ □ Soreness/weakness of lower body – location_____

NEUROLOGICAL & PSYCHOLOGICAL: □ 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 problems?_____

_____

SLEEP: # hours/night:_____ □ Insomnia □ Excess Quality (light/heavy):_____

Dreams? (Describe):_____

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

_____

_____

_____

_____