HISTORY QUESTIONNAIRE (2015)
Information for your Acupuncturist

Important: Complete this document as thoroughly as possible. Some of the questions that follow may seem unrelated to your condition, but they may play a major role in diagnosis and treatment. *All information is strictly confidential.*

I. General Patient Information

Date: ____/____/____

Name: Mr./Mrs./Ms._____

Address: _____

City, State, Zip Code: _____

Home Phone: _(_____)_____ Work Phone: _(_____)_____

Cell Phone: _(_____)_____ Email address:_____

Age: _____ Date of Birth: ____/____/____ Place of Birth: _____

Guardian (if under 18): _____

Emergency Contact (Name and Phone#)_____

Gender: □M □F Height: ____'____" Weight: _____lbs.

Social Security Number: _____-_____-_____ Driver's License Number:_____

Occupation:_____Employer:_____

PCP Name:_____ Specialist Name:_____

How did you hear about our office? _____

Major Complaint(s), in order of significance to you:

1. _____ 4. _____
2. _____ 5. _____
3. _____ Additional:_____

How do these conditions impair your daily activities?_____

_____

II. Patient Medical History

How was your childhood health?_____

Hospital Visits/Stays:_____

NEW PATIENT HEALTH HISTORY QUESTIONNAIRE

Dear New Patient:

a. Please **read** and **fill in** all of the information that pertains to you.
b. On pages 2 through 11, under each category, **check all current** symptoms that you experience either *acutely or chronically* .
c. **Add** and **total** all of the boxes you checked.
d. **Date** today's day.

	TEST	***DATE***	***TEST RESULTS***
	Physical		
	Cholesterol		
	Prostate		
	Mammography		
	Pap Smear		
	Blood (which test?)		
	HIV/STD		
	Other		

Please indicate if you have (or had) any of the following:							
	Diabetes		Allergies		Rheumatic Fever		Vein Condition
	Heart Disease		CVA (stroke)		Thyroid Disorder		Tuberculosis
	Asthma		Pneumonia		Emphysema		Chicken Pox
	High Blood Pressure		Gonnorhea		Bleeding Tendency		Polio
	Syphilis		Measles		Nervous Disorder		Migraines
	Meningitis		HIV		Mononucleosis		Other Liver Illnesses
	Epilepsy		High Fever		Multiple Sclerosis		Other Heart Illnesses
	Paralysis		Cancer		Jaundice		Other Kidney Illnesses
	Glaucoma		Mumps		Hepatitis		Other Lung Illnesses

IMMUNIZATIONS?

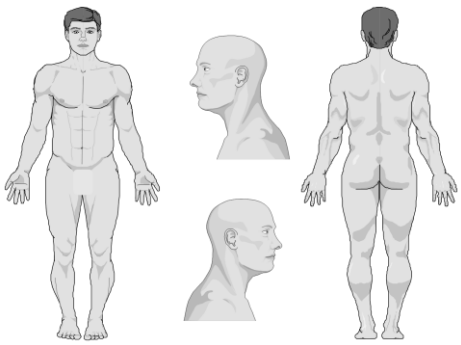
SURGERIES?

1. Pain:

On the figures below, please mark clearly any areas of pain and indicate any scars.

	What makes the pain better?
	Soft Preassure
	Hard Pressure
	Cold
	Heat
	Exercise
	Rest
	Other

	What makes the pain worse?
	Soft Pressure
	Hard Pressure
	Cold
	Heat
	Exercise
	Other



NEW PATIENT HEALTH HISTORY QUESTIONNAIRE

#1-#6: FOR LONG TERM-CARE PATIENTS ONLY: On the day of your RE-EXAM, only check the boxes that NO LONGER pertain to you, or if you HAVE NOT experienced the symptoms for two weeks. Add up your boxes and date.

2. Describe your pain:

		#1	#2	#3	#4	#5	#6
☐	Sharp						
☐	Fixed						
☐	Burning						
☐	Moving						
☐	Cramping						
☐	Aching						
☐	Dull						
☐	Other:_____						
☐	***Total Boxes Checked***						
	Date:_____ RE Date:	/	/	/	/	/	/

3. Kidney Function: (Overall Temperature)

		#1	#2	#3	#4	#5	#6
☐	Cold Hands						
☐	Cold Fingers						
☐	Cold Toes						
☐	Cold Feet						
☐	Sweaty Hands						
☐	Sweaty Feet						
☐	Hot Body Temperature Sensation						
☐	Cold Body Temperature Sensation						
☐	Afternoon Flushes						
☐	Night Sweats						
☐	Heat in the hands, feet & chest						
☐	Hot flashes any time of the day						
☐	Thirsty						
☐	Perspire easily						
☐	Lack of perspiration						
☐	Do you take water to bed						
☐	***Total Boxes Checked***						
	Date:_____ RE Date:	/	/	/	/	/	/

4. Lung, Kidney Function: (Overall Energy)

		#1	#2	#3	#4	#5	#6
☐	Shortness of Breath						
☐	Difficulty keeping eyes open (daytime)						
☐	General Weakness						
☐	Easily catch colds						
☐	Low Energy						
☐	Feel worse after exercise						
☐	Chronic (daily) fatigue & malaise						
☐	***Total Boxes Checked***						
	Date:_____ RE Date:	/	/	/	/	/	/

NEW PATIENT HEALTH HISTORY QUESTIONNAIRE

5. Liver, Spleen, Heart Function:

	#1	#2	#3	#4	#5	#6
☐ Dizziness						
☐ See floating black spots						
☐ ***Total Boxes Checked***						
Date:_____ RE Date:	/	/	/	/	/	/

6. Heart Function:

	#1	#2	#3	#4	#5	#6
☐ Anxiety						
☐ Sores on tip of tongue						
☐ Restlessness						
☐ Mental confusion						
☐ Chest pain traveling to shoulder						
☐ Frequent dreams						
☐ Wake unrefreshed						
☐ Coffee? How much per week?_____						
☐ ***Total Boxes Checked***						
Date:_____ RE Date:	/	/	/	/	/	/

7. Spleen Function:

	#1	#2	#3	#4	#5	#6
☐ Low Appetite						
☐ Abrupt Weight Gain						
☐ Abrupt Weight Loss						
☐ Abdominal Bloating						
☐ Abdominal Gas						
☐ Gurgling noise in Stomach						
☐ Fatigue after eating						
☐ Prolapsed Organs? Which?_____						
☐ Bruise easily?						
☐ Over-Thinking						
☐ Worry						
☐ ***Total Boxes Checked***						
Date:_____ RE Date:	/	/	/	/	/	/

8. Lung Function:

	#1	#2	#3	#4	#5	#6
☐ Nasal Discharge (color_____)						
☐ Cough						
☐ Nose Bleeds						
☐ Sinus Congestion						
☐ Dry Mouth						
☐ Dry Throat						
☐ Dry Nose						
☐ Dry Skin						
☐ Allergies (what?_____)						
☐ Alternating Chills/Fever						
☐ Sneezing						
☐ Headache (location_____)						
☐ Overall achy feeling in body						

NEW PATIENT HEALTH HISTORY QUESTIONNAIRE

- [ ] Stiff Neck
- [ ] Stiff Shoulders
- [ ] Sore Throat
- [ ] Difficulty breathing
- [ ] Smoke cigarettes (# per day_____)
- [ ] Sadness
- [ ] Melancholy

	#1	#2	#3	#4	#5	#6
Total Boxes Checked						
RE Date:	/	/	/	/	/	/

Date:_____

9. Spleen, Stomach, Small/Large Intestine Functic

	#1	#2	#3	#4	#5	#6
☐ Loose Stools						
☐ Constipated						
☐ Incomplete Stools						
☐ Diarrhea						
☐ Blood in Stools						
☐ Mucous in Stools						
☐ Undigested food in the Stools						
Total Boxes Checked						
RE Date:	/	/	/	/	/	/

Date:_____

10. Stomach Function:

	#1	#2	#3	#4	#5	#6
☐ Burning sensation after eating						
☐ Large appetite						
☐ Bad Breath						
☐ Canker Sores (mouth)						
☐ Bleeding, swollen or painful gums						
☐ Heartburn						
☐ Acid Regurgitation						
☐ Ulcer (diagnosed?)						
☐ Belching						
☐ Hiccups						
☐ Stomach Pain						
☐ Vomiting						
Total Boxes Checked						
RE Date:	/	/	/	/	/	/

Date:_____

11. Dampness trapped in the Body:

	#1	#2	#3	#4	#5	#6
☐ Bodily sensation of heaviness						
☐ Mental heaviness						
☐ Mental sluggishness						
☐ Mental fogginess						
☐ Swollen hands						
☐ Swollen feet						
☐ Swollen joints						
☐ Chest congestion						
☐ Nausea						
☐ Snoring						

NEW PATIENT HEALTH HISTORY QUESTIONNAIRE

☐ ***Total Boxes Checked***
Date:_____ RE Date: ☐ ☐ ☐ ☐ ☐ ☐

12. Liver Function (eyes):

	#1	#2	#3	#4	#5	#6
☐ Itchy						
☐ Bloodshot						
☐ Hot						
☐ Dry						
☐ Watery						
☐ Gritty						
☐ Blurry Vision						
☐ Decreased Night Vision						
☐ Near-sighted						
☐ Far-sighted						

☐ ***Total Boxes Checked***
Date:_____ RE Date: ☐ ☐ ☐ ☐ ☐ ☐

13. Liver, Gall Bladder Function:

☐ Alternating Diarrhea & Constipation						
☐ Chest Pain						
☐ Tight sensation in the Chest						
☐ Bitter taste in the mouth						
☐ Anger easily						
☐ Depression						
☐ Frustration						
☐ Irritability						
☐ Skin Rashes						
☐ Headache at the top of the Head						
☐ Tingling Sensation						
☐ Numbness						
☐ Muscle twitching						
☐ Muscle cramping						
☐ Muscle Spasms						
☐ Seizures						
☐ Convulsions						
☐ Lump in the throat						
☐ Neck Tension						
☐ Shoulder Tension						
☐ Limited Range-of-Motion (Neck)						
☐ Limited Range-of-Motion (Shoulder)						
☐ How much Alcohol / day?_____						
☐ Recreational drugs (which?_____)						
☐ High-pitched Ringing in Ears						
☐ Gallstones (history or current)						
☐ STD's (which?_____)						
☐ Unable to adapt to Stress						

☐ ***Total Boxes Checked***
Date:_____ RE Date: ☐ ☐ ☐ ☐ ☐ ☐

NEW PATIENT HEALTH HISTORY QUESTIONNAIRE

14. Kidney, Urinary Bladder Function:

		#1	#2	#3	#4	#5	#6
☐	Frequent cavities, teeth problems						
☐	Easily broken bones						
☐	Sore knees						
☐	Weak knees						
☐	Cold sensation in the knees						
☐	Low Back Pain						
☐	Memory problems						
☐	Excessive hair loss						
☐	Low-pitched ringing in the ears						
☐	Kidney Stones						
☐	Bladder Infections						
☐	Lack of bladder control						
☐	Wake during the night 2 (or more) times to urinate?						
☐	Fear						
☐	Easily startled						
☐	***Total Boxes Checked***						
Date:_____	RE Date:	⁄	⁄	⁄	⁄	⁄	⁄

15. Libido:

		#1	#2	#3	#4	#5	#6
☐	Normal						
☐	High						
☐	Low						
☐	***Total Boxes Checked***						
Date:_____	RE Date:	⁄	⁄	⁄	⁄	⁄	⁄

16. Urination (Bladder Function):

	Color (please check):	#1	#2	#3	#4	#5	#6
☐	Pale____; Dk Yellow____; Clear____						
☐	Reddish						
☐	Cloudy						
☐	Scanty						
☐	Profuse						
☐	Strong Oder						
☐	Burning						
☐	Painful						
☐	Discharge						
☐	Difficult						
☐	Urgent						
☐	Frequent						
☐	***Total Boxes Checked***						
Date:_____	RE Date:	⁄	⁄	⁄	⁄	⁄	⁄

NEW PATIENT HEALTH HISTORY QUESTIONNAIRE

WOMEN ONLY			
☐ Yes ☐ No	Do you have a regular menstrual cycle?	_____	Age of first menstruation
☐ Yes ☐ No	Are you pregnant?	_____	Average number of days in flow
☐ Yes ☐ No	Do you have bleeding beetween periods?	_____	Average number of days in entire cycle
☐ Yes ☐ No	Do you have a vaginal discharge?	_____	Number of children
		_____	Number of pregnancies
		_____	Age of menopause (if applicable)

Please fill in the menstrual chart:	Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7
Color (choose one): normal, pale, bright red, brown rust, dark purple, other							
Amount of flow (choose one): normal, heavy, light							
Pain/Cramps (choose one): dull, sharp, other							
Vomiting (check if yes):							
Nausea (check if yes):							

Women Only:

	#1	#2	#3	#4	#5	#6
☐ Nausea						
☐ Vomiting						
☐ Food cravings						
☐ Water retention						
☐ Breast swelling						
☐ Breast tenderness						
☐ Headaches						
☐ Migraines						
☐ Dull pain (where?_____)						
☐ Sharp pain (where?_____)						
☐ Depression						
☐ Irritability						
☐ Anxiety						
☐ Other (explain_____)						
☐ ***Total Boxes Checked***						
Date:_____ RE Date:						

Men Only:

	#1	#2	#3	#4	#5	#6
☐ Swollen testes						
☐ Testicular pain						
☐ Impotence						
☐ Premature ejaculation						
☐ Feeling of coldness or Numbnesss in external genitalia						
☐ Other?						
☐ ***Total Boxes Checked***						
Date:_____ RE Date:						