HEALTH HISTORY QUESTIONNAIRE

Please help us provide you with 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 questions, please ask. If thereis anything you wish to bring to our attention which is not asked on this form, please note it in the "Comments" section. Thank you.

Name_____ Date_____

Street City State/Zip_____

Home Phone_____ Work Phone_____

eMail _____

Age: _____ Date of Birth _____ Male__ Female__ Height_____ Weight_____

Occupation:_____ Retired:__ Disabled:__ Unemployed:__

Family Physician:_____ Referred by: _____

Emergency contact name, telephone number and relation to you: _____
_____

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? Please be specific:
_____

Have you been given a diagnosis for this problem? If so, what diagnosis and by whom?

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

What other kinds of treatment have you tried?

□ Western Medicine □ Acupuncture □ Herbs

□ Massage □ Physical Therapy □ Chiropractor

□ Reiki □ Homeopathy □ Other: _____

Secondary Complaints you would like us to help you with:_____

_____

_____

Past Personal Medical History of Significant Illnesses:

□ Asthma □ Allergies □ Diabetes □ Cancer □ Stroke □ Heart disease

□ High Blood Pressure □ Seizures □ Hepatitis □ Rheumatic Fever

□ Thyroid disease □ Venereal disease □Other:_____

Hospitalizations/Surgeries (including dates):_____

_____

_____

Family Medical History: (check all that are applicable)

□ Asthma □ Allergies □ Diabetes □ Cancer □ Stroke □ Heart disease

□ High Blood Pressure □ Seizures □ Thyroid □ Hepatitis □ Rheumatic Fever

□ Thyroid disease □ Venereal disease □ Others:_____

Medicines taken within the last two months (vitamins, drugs, herbs, etc):

MEDICATIONS	DOSAGE	REASON

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? _____

Describe your average daily diet:

Morning:_____

Afternoon: _____

Evening: _____

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?_____

GENERAL:

□ Fevers □ Chills □ Fatigue □ Sweat easily □ Poor sleeping

□ Night sweats □ Weight loss □ Cravings □ Weight gain

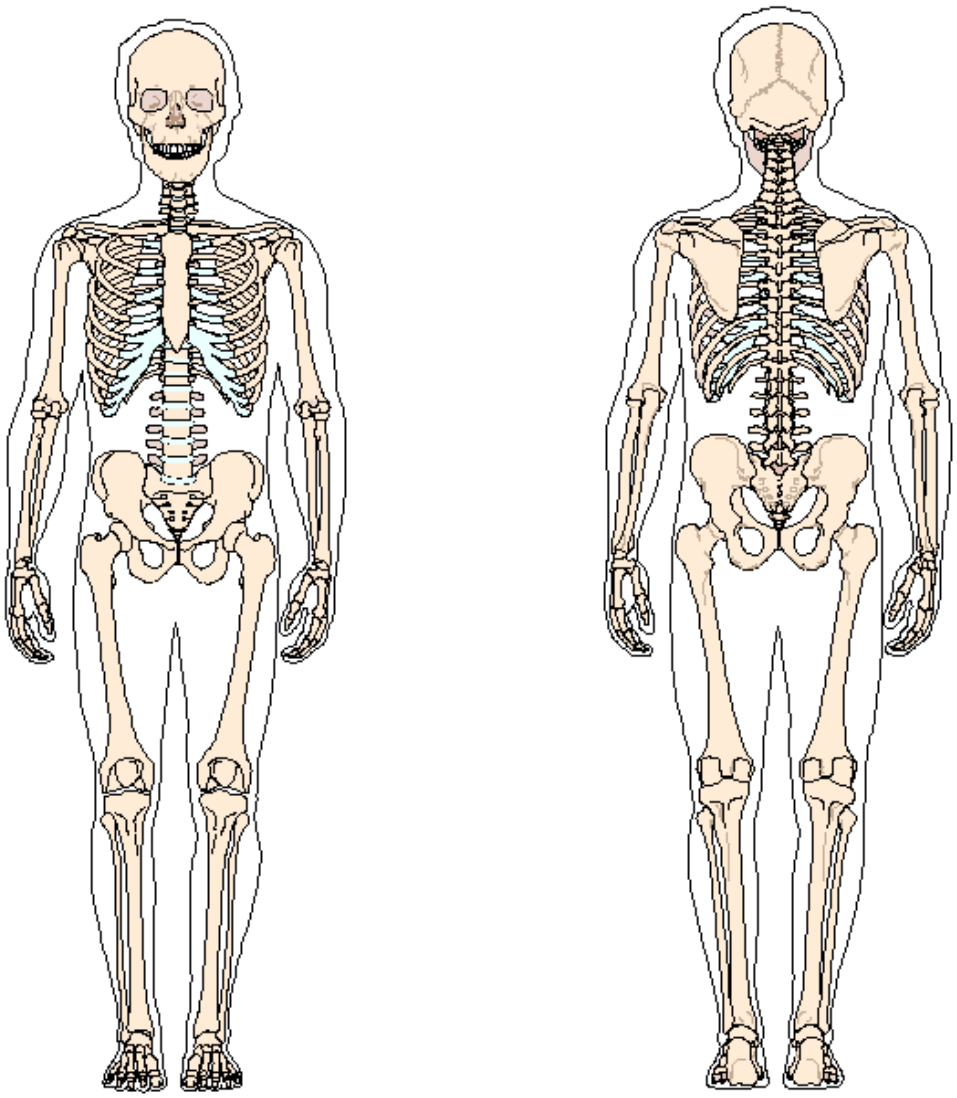
□ Change in appetite □ Strong thirst for: □ Hot drinks □ Cold drinks

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

□ Bleed or bruise easily □ Peculiar tastes or smells □ Hepatitis: A B C D E

□ HIV □ AIDS □ STD

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



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

SKIN & HAIR:

□ Rashes □ Ulcerations □ Hives □ Itching □ Eczema □ Pimples

□ Dandruff □ Loss of hair □ Psoriasis □ Dermatitis □ Acne □ Recent moles

□ Change in hair or skin texture □ Any other skin or hair problems? _____

HEAD, EYES, EARS, NOSE & THROAT:

□ Dizziness	□ Concussions	□ Migraines	□ Glasses
□ Eye pain	□ Poor vision	□ Night blindness	□ Cataracts
□ Blurry vision	□ Earaches	□ Sinus problems	□ Ringing in ears
□ Spots in front of eyes	□ Poor hearing	□ Nose bleeds	□ Recurrent sore throats
□ Grinding teeth	□ Clenching jaw	□ Facial pain	□ Sores on lips or tongue
□ Teeth problems	□ Jaw clicks	□ Color blindness	□ Headaches, where and

when?_____ □ Any other head or neck problems?_____

CARDIOVASCULAR:

□ High blood pressure	□ Low blood pressure	□ Chest pain □ Fainting
□ Irregular heart beat	□ Difficulty in breathing	□ Blood clots □ Phlebitis
□ 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 up blood	□ Asthma	□ Bronchitis
□ Pneumonia	□ Pain with deep breath	□ Chest tightness	
□ Difficulty breathing when lying down		□ Phlegm production, what color?_____	

GASTROINTESTINAL:

□ Nausea	□ Vomiting	□ Diarrhea	□ Constipation	□ Gas
□ Belching	□ Black/dark 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 □ 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? _____

REPRODUCTIVE & GYNECOLOGIC:

Are you pregnant? □ Yes □ No

Is it possible that you are pregnant? □ Yes □ No

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

Abortions: _____ Premature births:_____

Age at first menses: _____ Time period between menses:_____

Duration of menses:_____ Last PAP: _____

□ Irregular periods □ Painful periods □ Clots □ Breast lumps

□ Vaginal sores □ Vaginal discharge □ Vaginal dryness □ Endometriosis

□ Uterine fibroids □ Polycystic Ovarian disease □ Fibrocystic breast tissue

□ Unusual character of blood (heavy, scanty)_____

Do you practice birth control? □ No □ Yes, what type? _____ How long? ____

MALE DISEASES:

□Frequent night/day urination □ Painful urination □Prostate pain

□ Stop & go flow of urine □ Difficulty in starting urination □ Erection problem

□ Premature ejaculation □ Low sperm count or/and motility

MUSCULOSKELETAL:

□ 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 & 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?_____

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

_____

_____

_____

_____

_____