



HEALTH HISTORY

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 there is anything else you would like to mention please do so in the comment section.

Name: _____ **Date** _____

Street: _____ **City:** _____ **State/Zip** _____

Home Phone: _____ **Work Phone:** _____ **eMail:** _____

Age: _____ **Date of Birth:** _____ **Gender:** _____ **Height:** _____ **Weight:** _____

How did you hear about us: _____

Were you referred by someone? If so, who? _____

- Race:** American Indian or Alaska native Asian Black or African American
 Native Hawaiian or Other Pacific Islander White
 Prefer not answer

Ethnicity: Hispanic or Latino Not Hispanic or Latino Prefer not answer

Marital Status: Married Never Married Widowed Divorced or Separated

Education: Grammar School High School College Masters Doctorate

Occupation: _____ **Retired:** _____ **Disabled:** _____ **Unemployed:** _____

Family Physician: _____

Emergency Contact: _____ **Emergency Contact Relation to you:** _____

Emergency Contact telephone: _____

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

Main Problem you would like to focus on: _____

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?

What other kinds of treatment have you tried? Western Medicine Acupuncture
 Herbs Massage Physical Therapy Chiropractor Reiki
 Homeopathy Other: _____

How confident are you that Acupuncture and Chinese herbal medicine will be able to resolve the symptoms of your main complaint?

Not confident Slightly confident Moderately confident Confident Very confident

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): _____

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

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

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

Other: _____

Medicines 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? _____

Describe your average daily diet:

Morning: _____

Afternoon: _____

Evening: _____

Do you smoke (Includes Vape & Marijuana)? No Yes If Yes, how often? _____

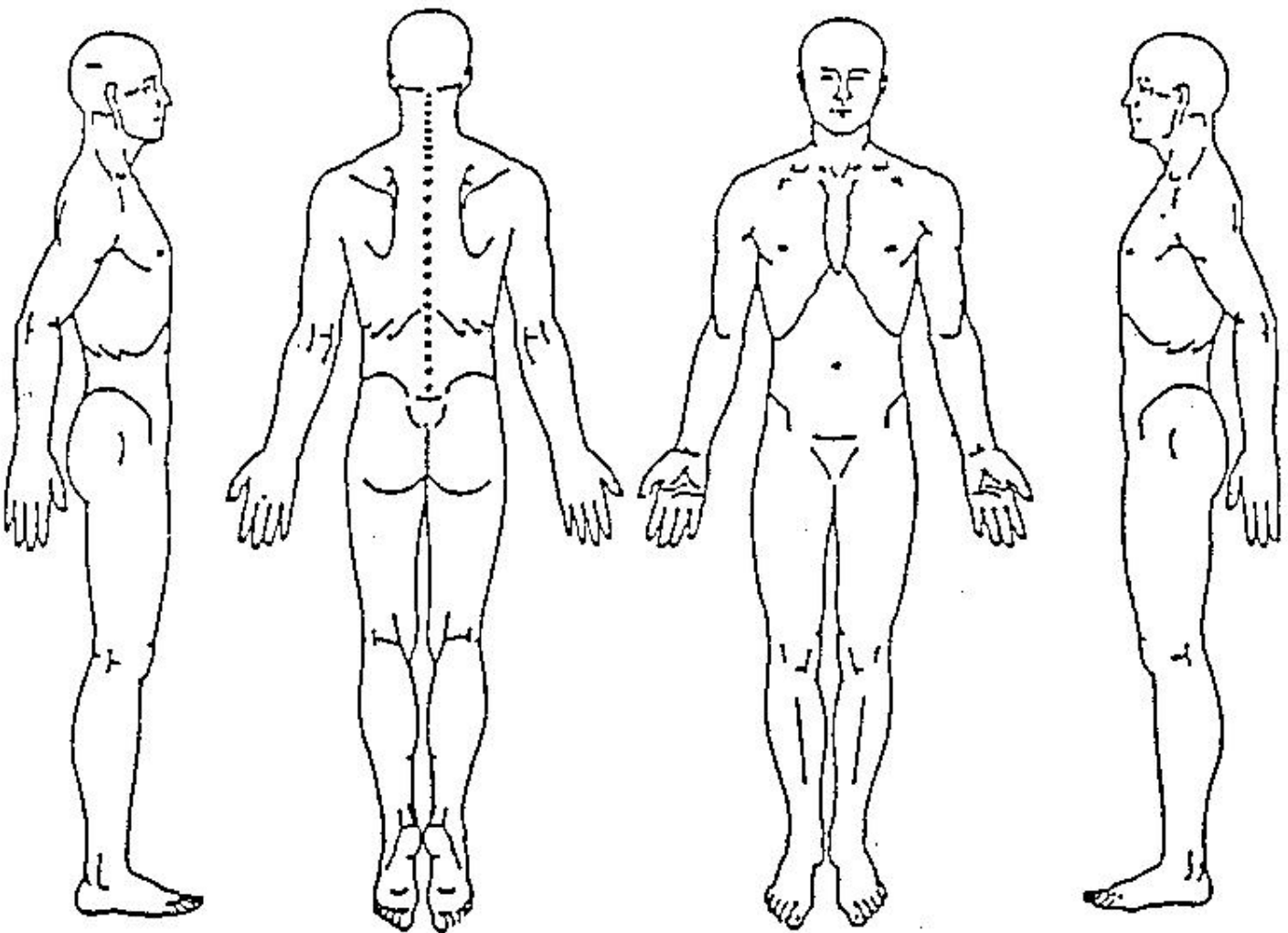
How many cups of caffeinated coffee, tea, or cola do you drink per week? _____

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 drugs for non - medical purposes: _____

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:

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

SKIN & HAIR:

- Rashes
- Ulcerations
- Hives
- Itching
- Eczema
- Pimples
- Dandruff
- Loss of hair
- Recent moles
- Psoriasis
- Dermatitis
- Acne
- Change in hair or skin texture
- Any other skin or hair problems? _____

HEAD, EYES, EARS, NOSE & THROAT:

- Dizziness
- Concussions
- Migraines
- Glasses
- Eye strain
- Eye pain
- Poor vision
- Night blindness
- Color blindness
- Cataracts
- Blurry vision
- Earaches
- Ringing in ears
- Spots in front of eyes
- Poor hearing
- Sinus problems
- Nose bleeds
- Recurrent sore throats
- Grinding teeth
- Clenching jaw
- Facial pain
- Sores on lips or tongue
- Teeth problems
- Jaw clicks
- 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 or blood vessel problems? _____

RESPIRATORY:

- Cough
- Coughing 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 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? Yes No If yes, what type? _____ How long? _____

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.*
