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HEALTH TRADITIONS

Health History Questionnaire

Name: _____ **Birthday**: _____

Address: _____ **City**: _____ **State**: _____ **Zip**: _____

Home Ph: _____ **Work Ph**: _____ **E-mail**: _____

Employer: _____ **Occupation**: _____

Insurance Info _____ **Height**: _____ **Weight**: _____ **Sex**: M / F

Marital Status (circle one): Never Married / Married / Separated / Living with Partner / Divorced / Widowed

Family Physician: _____ **Referred By**: _____

Emergency Contact Name and Number: _____

Have you ever been treated by Acupuncture or Oriental Medicine before? _____

What is your main concern(s) that you would like help with? _____

_____

When did this begin? (Please be specific.) _____

_____

What do you think caused it? Is the cause still present? _____

_____

Have you been given a diagnosis for this condition? If so, what? _____

What kind of treatments have you tried? What were the results? _____

_____

To what extent does this condition interfere with your daily activities (eg. work, sleep, eating, sex) ? _____

_____

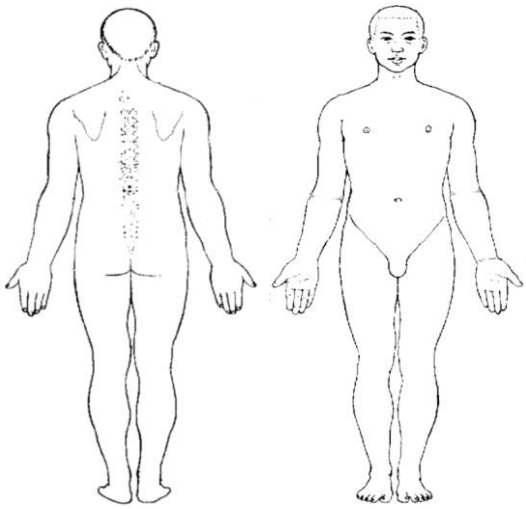
Please note the degree of severity of your problem now:

No problem Moderate Worst Imaginable

Please note the greatest degree of severity of your problem within the last week:

No problem Moderate Worst Imaginable

Please indicate painful or distressed areas on the diagrams to the right.



Past Medical History (please indicate by date):

Cancer: _____ Pacemaker: _____ High Blood Pressure: _____
Diabetes: _____ Rheumatic Fever: _____ Stroke: _____
Hepatitis: _____ Heart Disease: _____ STD: _____
Other Conditions: _____

Surgeries (type and date): _____
_____

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

Significant Dental Work (type and date): _____
_____

Additional Medications / Herbs / Supplements you are currently taking: _____
_____
_____

Occupational Stress (physical, chemical, psychological, etc.): _____
_____

Do you exercise regularly? Y / N Please describe: _____
_____

Last Physical Date: _____ Doctor: _____ Results: _____

Habits Please indicate below: None, Light, Moderate, or Heavy. Please add comments where significant.

	Excessive	Moderate	Minimal	None	
Alcohol:	☐	☐	☐	☐	
Coffee / Tea:	☐	☐	☐	☐	
Tobacco:	☐	☐	☐	☐	
Exercise:	☐	☐	☐	☐	
Sleep:	☐	☐	☐	☐	
Appetite:	☐	☐	☐	☐	
Energy Level:	☐	☐	☐	☐	
Medication:	☐	☐	☐	☐	
Vitamins:	☐	☐	☐	☐	
Food Intake:	☐	☐	☐	☐	
Drugs:	☐	☐	☐	☐	
Salt Intake:	☐	☐	☐	☐	
Stress Level:	☐	☐	☐	☐	
Other:	☐	☐	☐	☐	

Diet Please give a general description of the food you eat during a "typical" day.

Morning: .....

Afternoon: .....

Evening: .....

Between meals: .....

Are you now, or have you ever been, on a restricted diet? Please describe the diet and give the start/stop dates:

_____

_____

What allergies do you have? What reactions do you have to these chemicals, foods, drugs, animals, etc?

_____

_____

Family Medical History

☐ High Blood Pressure	☐ Alcoholism	☐ Cancer: _____	☐ Allergies: _____
☐ Heart Disease	☐ Seizures	_____	_____
☐ Arteriosclerosis	☐ Asthma	_____	_____
☐ Stroke	☐ Diabetes		

General

- ☐ Chills
- ☐ Fevers
- ☐ Sweat easily
- ☐ Night sweats
- ☐ Localized weakness
- ☐ Bleed or bruise easily
- ☐ Peculiar tastes or smells
- ☐ Strong thirst (cold / hot)
- ☐ Thirst, no desire to drink
- ☐ Fatigue
- ☐ Sudden energy drop
  *Time of day:*_____
- ☐ Edema
  *Where:*_____
- ☐ Poor sleeping
- ☐ Tremors
- ☐ Poor balance
- ☐ Cravings
- ☐ Change in appetite
- ☐ Poor appetite
- ☐ Weight change
  Gain / Loss _____

Skin and Hair

- ☐ Rashes
- ☐ Itching
- ☐ Change in hair or skin
- ☐ Ulcerations
- ☐ Eczema
- ☐ Oozing skin lesion
- ☐ Hives
- ☐ Pimples
- ☐ Recent moles
- ☐ Loss of hair
- ☐ Dandruff

Other hair or skin problems

_____

_____

Head, Eyes, Ears Nose, and Throat

- ☐ Dizziness
- ☐ Migraines
- ☐ Headaches
- ☐ Facial pain
- ☐ Glasses
- ☐ Poor vision
- ☐ Night blindness
- ☐ Blurry vision
- ☐ Color blindness
- ☐ Blind field
- ☐ Spots in front of eyes
- ☐ Eye pain
- ☐ Eye strain
- ☐ Cataracts
- ☐ Eye Dryness
- ☐ Excessive tearing
- ☐ Discharge from eyes
- ☐ Poor hearing
- ☐ Ringing in ears
- ☐ Earaches
- ☐ Discharge from ear
- ☐ Nose bleeds
- ☐ Sinus congestion
- ☐ Nasal drainage
- ☐ Grinding teeth
- ☐ Teeth problems
- ☐ Jaw clicks
- ☐ Concussions
- ☐ Recurrent sore throats
- ☐ Hoarseness
- ☐ Sores on lips/tongue

Other head / neck problems

Cardiovascular

- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Chest discomfort/pain
- ☐ Heart palpitations
- ☐ Cold hands or feet
- ☐ Swelling of hands
- ☐ Swelling of feet
- ☐ Blood clots
- ☐ Fainting
- ☐ Difficulty in breathing

Other heart/blood vessel problems: _____

Respiratory

- ☐ Cough
- ☐ Asthma/wheezing
- ☐ Difficulty in breathing when lying down
- ☐ Phlegm *Color?*_____
- ☐ Coughing blood
- ☐ Pneumonia
- ☐ Bronchitis

*Other lung problems:*_____

_____

Gastrointestinal

- ☐ Bad breath
- ☐ Nausea
- ☐ Vomiting
- ☐ Heartburn
- ☐ Belching
- ☐ Indigestion
- ☐ Diarrhea
- ☐ Constipation
- ☐ Chronic laxative use
- ☐ Blood in stools
- ☐ Black stools
- ☐ Abdominal pain/cramps
- ☐ Gas
- ☐ Rectal pain
- ☐ Hemorrhoids

*Other stomach or intestinal problems:*_____

_____

Genito-Urinary

- ☐ Pain on urination
- ☐ Urgency to urinate
- ☐ Frequent urination
- ☐ Blood in urine
- ☐ Decrease in flow
- ☐ Dribbling
- ☐ Kidney stones
- ☐ Impotency
- ☐ Change of sexual drive
- ☐ Sores on genitals

Do you wake to urinate?

☐ Yes ☐ No

How often? _____

What color is your urine?

_____

*Other genital or urinary system problems?*_____

_____

Pregnancy and Gynecology

of pregnancies: _____
# of births: _____
premature births: _____
of miscarriages: _____
# of abortions: _____
Age at first menses: _____
Length of full cycle: _____
Length of menses: _____
Last menses start date: _____

- ☐ Heavy periods
- ☐ Light periods
- ☐ Painful periods
- ☐ Irregular periods
- ☐ Changes in body/psyche prior to menstruation
- ☐ Clots
- ☐ Vaginal discharge:
- ☐ Menopause:
  Age: _____
  *Year:*_____
- ☐ Postcoital bleeding
- ☐ Vaginal sores
- ☐ Breast lumps
- ☐ Nipple discharge

Do you practice birth control?

☐ Yes ☐ No

What type and for how long?

_____

Musculoskeletal

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

Other pain? _____

_____

Neuropsychological

- ☐ Seizures
- ☐ Areas of numbness
- ☐ Weakness
- ☐ Sleep disorder
- ☐ Concussion
- ☐ Violence potential
- ☐ Vertigo
- ☐ Lack of coordination
- ☐ Bad temper
- ☐ Depression
- ☐ Easily stressed
- ☐ Loss of balance
- ☐ Poor memory
- ☐ Anxiety
- ☐ Substance abuse

Have you ever been treated for emotional problems?

☐ Yes ☐ No

* Please check any symptoms you have had in the past month