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 there is 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/Cell phone**_____

Email _____

Age_____**Date of Birth**_____**Male**_____**Female**_____**Height**_____**Weight**_____

Marital Status: Married_____Never Married_____Widowed_____Divorced or Separated_____

Education: Grammar School _____High School _____College_____Masters_____Doctorate_____

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

Family Physician:_____**Referred by:**_____

Emergency Contact: _____**Relationship to you:**_____

Emergency Contact phone number/s:_____

Have you ever been treated by acupuncture or Oriental Medicine before? Yes_____ No_____

Main problem you would like help 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?_____

_____

What other kinds of treatment have you tried? Western medicine_____ Acupuncture_____

Herbs _____ Massage_____ Physical Therapy_____ Chiropractor_____ Reiki_____ Homeopathy_____

Other_____

To what extent does this problem affect your daily activities (work, sleep, eating, etc.)? _____

_____

Secondary complaints you would like help 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_____HIV_____

Hemophiliac_____ Birth trauma (prolonged labor, forceps delivery, cesarean section, etc.) _____

If yes, please explain_____

Other:_____

Hospitalizations/Surgeries (including dates):_____

_____

_____

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

_____

_____

Allergies (drugs, chemicals, metals, foods, essential oils, etc.):_____

_____

Family Medical History: (check all that are applicable) Asthma_____ Allergies_____

Diabetes_____ Cancer_____ Stroke_____ Heart disease_____ High blood pressure_____

Seizures _____ Hepatitis_____ Rheumatic Fever_____ Thyroid disease_____ HIV_____

Venereal disease_____ Hemophiliac_____ Other_____

Medicines taken within the last two months (include vitamins, drugs, herbs, homeopathy, 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? _____

Please describe your typical 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?_____

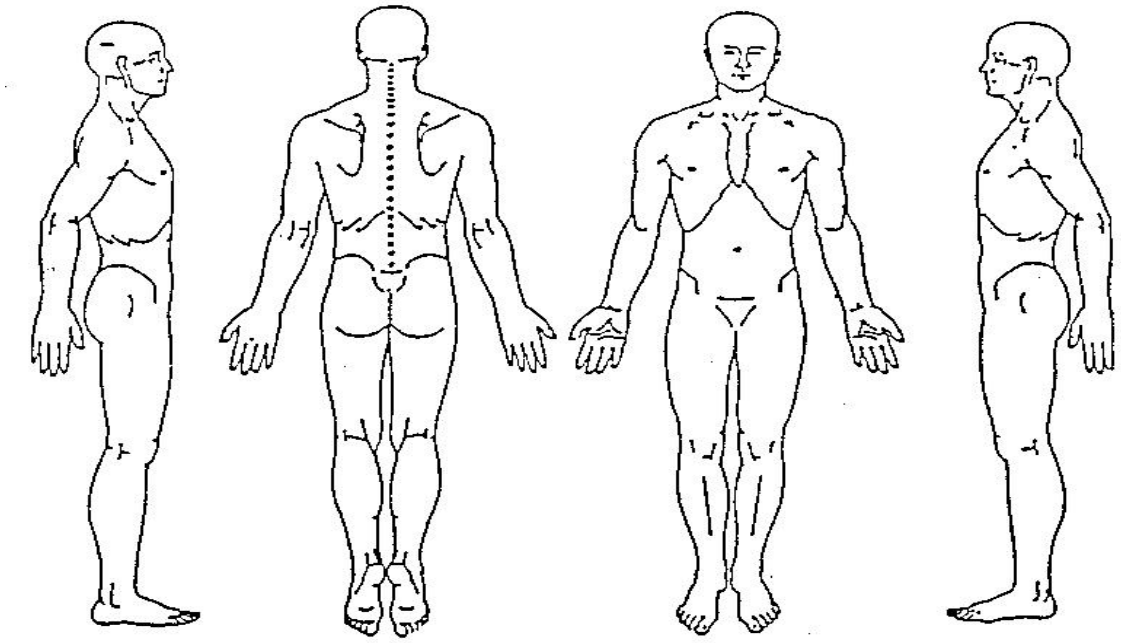
How many 8 oz. glasses of water do you drink per day? _____

How many alcoholic beverages do you drink per week? _____

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 Sleep _____ Night sweats_____ Weight Loss_____ Cravings_____

Weight Gain _____ Change in appetite ____ Sudden drop in energy, if so what time of day?_____

Strong thirst for_____ Hot drinks_____ Cold drinks_____

Bleed or bruise easily? _____ Peculiar tastes or smells _____

SKIN & HAIR:

Rashes_____ Ulcerations_____ Hives_____ Itching_____

Eczema_____ Acne_____ Dandruff_____ Loss of hair_____

Recent moles_____ Psoriasis_____ Dermatitis_____

Change in hair or skin texture_____ Any other skin or hair problems?_____

Facial Rejuvenation Clients (only):

Have you ever had a face lift?_____If so, when?_____

Do you have any facial implants?_____ If so, what kind and where?_____

Have you received Botox or any other Injectable?_____ If so, when?_____

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_____ If yes, how often and where_____

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_____ Pacemaker_____

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_____ Lose stools, more than 2 per day_____

Any other problems 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_____ Prostate problems_____ Sores on genitals_____

Any particular color to your urine?_____

Do you wake up at night to urinate?_____ If yes, how many times per 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:_____

Last mammogram:_____ Results:_____

Irregular periods_____ Painful periods_____ Clots_____ Breast Lumps_____

Vaginal sores_____ Vaginal discharge_____ Vaginal dryness_____ Endometriosis_____

Uterine fibroids_____ Polycystic Ovarian disease (PCOS)_____ Fibrocystic breast tissue_____

Character of blood (heavy, scanty)_____

Do you practice birth control? Yes___ No___ If yes, what type?_____ For how long?_____

First day of last menses:_____ Other problems?_____

_____

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_____ Hip pain_____

Back pain: Low_____ Middle_____ Upper_____

Soreness/weakness of lower body (back, hip, knee, ankle, foot) _____

NEUROLOGICAL & PSYCHLOGICAL:

Seizures_____ Dizziness_____ Loss of balance_____ Concussion_____

Poor memory_____ Poor coordination_____ Bad Temper_____ Anxiety_____

Depression_____ Easily susceptible to stress_____ Nervousness_____

ADD/ADHD_____ Manic depression_____

Numbness or tingling?_____ If yes, where and for how long?_____

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 briefly explain any other problems you would like to discuss.* _____

_____

_____

_____

_____