

**CONFIDENTIAL HEALTH HISTORY**

Welcome! Please take the time to fill out this questionnaire fully. Your answers are strictly confidential. If you have any questions, please feel free to ask.

Today's Date \_\_\_\_\_

Name \_\_\_\_\_ Date/Place of Birth \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Tel: Work \_\_\_\_\_ Home \_\_\_\_\_ Cell \_\_\_\_\_

E-mail \_\_\_\_\_ Age \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_ Sex \_\_\_\_\_

Occupation \_\_\_\_\_ Referred by \_\_\_\_\_

Name & Tel# of Physician \_\_\_\_\_

Emergency Contact Name & Tel# \_\_\_\_\_ Relationship \_\_\_\_\_

What would you like treated by acupuncture? \_\_\_\_\_

How and when did this condition develop? \_\_\_\_\_

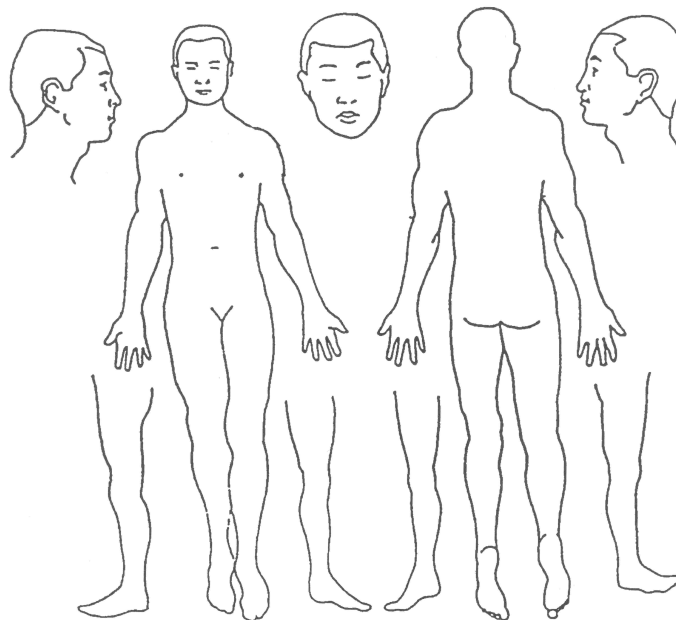
How has this condition affected your daily activities? \_\_\_\_\_

What medical diagnosis have you received, if any? \_\_\_\_\_

What kinds of treatment or therapy have you tried? \_\_\_\_\_

**Are you currently pregnant? \_\_\_\_\_ Are you presently trying to become pregnant? \_\_\_\_\_**

**Please mark any areas of pain or distress on the diagram below:**



**Medical History** Please check off current or former conditions and include dates and relevant information.

- AIDS/HIV \_\_\_\_\_ any neuropathies? \_\_\_\_\_
- Alcoholism \_\_\_\_\_
- Allergies \_\_\_\_\_
- Asthma \_\_\_\_\_ difficulty inhaling  difficulty exhaling
- Cancer \_\_\_\_\_
- Diabetes \_\_\_\_\_ any neuropathies? \_\_\_\_\_
- Emphysema \_\_\_\_\_
- Hepatitis A/B/C - please specify \_\_\_\_\_
- Heart Disease \_\_\_\_\_
- Herpes - Type \_\_\_\_\_
- Lyme disease \_\_\_\_\_
- Lymph Nodes removed - where? \_\_\_\_\_ can you have injections on that side? \_\_\_\_\_
- Multiple Sclerosis \_\_\_\_\_
- Pacemaker \_\_\_\_\_
- Rheumatic or Scarlet Fever \_\_\_\_\_
- Seizures \_\_\_\_\_
- Thyroid disease \_\_\_\_\_
- Tuberculosis \_\_\_\_\_
- Venereal disease \_\_\_\_\_

**Vaccinations** Any reaction that you remember? Any unusual vaccinations?

\_\_\_\_\_

**Please describe any significant injuries/trauma, illnesses, or surgeries:**

Birth trauma, if any \_\_\_\_\_

Age \_\_\_\_\_

Age \_\_\_\_\_

Age \_\_\_\_\_

Age \_\_\_\_\_

Age \_\_\_\_\_

Age \_\_\_\_\_

Age \_\_\_\_\_

**Scars** from injury/surgery (even minor):

\_\_\_\_\_

**Medications** Please list medications (including over-the counter), herbs, and supplements you are taking.

\_\_\_\_\_

\_\_\_\_\_

**Family Medical History** Please list major illnesses in your close family such as diabetes, heart disease, high blood pressure, neurological disorders, psychological disorder, orthopedic disorders, etc.

\_\_\_\_\_

\_\_\_\_\_

**General**

Describe typical meals:

Breakfast \_\_\_\_\_  
Lunch \_\_\_\_\_  
Dinner \_\_\_\_\_  
Snacks \_\_\_\_\_

Are you vegan? \_\_\_\_\_  
Lacto / ovo vegetarian? \_\_\_\_\_  
How long? \_\_\_\_\_

Any food cravings? \_\_\_\_\_  
Any food intolerances? \_\_\_\_\_  
Are you always thirsty? \_\_\_\_\_ Never thirsty? \_\_\_\_\_ Thirsty, but no desire to drink? \_\_\_\_\_  
Do you prefer Hot or Cold drinks? \_\_\_\_\_

Rate taste preferences from 1 to 5 (1=like most, 5=dislike): Sour\_\_\_ Bitter\_\_\_ Sweet\_\_\_ Spicy\_\_\_ Salty\_\_\_

How much and how often do you have the following:

Sugar / Sweets \_\_\_\_\_  
Coffee, tea, or cola \_\_\_\_\_  
Water \_\_\_\_\_  
Alcoholic beverages \_\_\_\_\_  
Cigarettes \_\_\_\_\_ per day for \_\_\_\_\_ years

How often do you have a bowel movement? \_\_\_\_\_  
How is your energy? \_\_\_\_\_ What time of day is it highest? \_\_\_\_\_ lowest? \_\_\_\_\_  
What kind of exercise do you do? \_\_\_\_\_  
How often? \_\_\_\_\_ Do you fatigue easily? \_\_\_\_\_  
Any unusual sweating? \_\_\_\_\_ Describe \_\_\_\_\_

**Emotions and Sleep**

How do you feel emotionally?

\_\_\_\_\_

Do you have (check all that apply):  depression  anxiety  panic attacks  irritability or short temper  
 poor memory  difficult concentration other \_\_\_\_\_  
 Married/stable relationship  Single  
How do you feel about your relationship? \_\_\_\_\_  
How do you feel about your work? \_\_\_\_\_  
How / where do you hold stress? \_\_\_\_\_  
How do you relax? \_\_\_\_\_  
How many hours do you generally sleep per night? \_\_\_\_\_ Do you have night sweats? \_\_\_\_\_  
Do you have trouble  falling asleep  staying asleep  disturbed sleep describe \_\_\_\_\_  
Do you use  anti-depressants  sleeping pills  other \_\_\_\_\_

**Women**

Age at first menses \_\_\_\_\_ days between cycles \_\_\_\_\_ duration of flow \_\_\_\_\_  
Color/quality of blood \_\_\_\_\_ birth control type \_\_\_\_\_  
Number of pregnancies \_\_\_\_\_ deliveries \_\_\_\_\_ abortions/miscarriages \_\_\_\_\_ age at menopause \_\_\_\_\_  
Pregnancy complications \_\_\_\_\_  
Vaginal discharge: amount \_\_\_\_\_ color \_\_\_\_\_ quality \_\_\_\_\_ frequency \_\_\_\_\_

Please **(Circle)** any problem you have now, **Underline** items that have affected you in the past

**Skin, Hair, Nails:** dry skin - rashes - itching - acne - eczema - hives - ulcerations - fungal infections - psoriasis - dry hair - dandruff - hair loss - brittle nails - other \_\_\_\_\_

**Cardiovascular:** Have you been diagnosed with any heart trouble? \_\_\_\_\_  
pacemaker - fast pulse >100 bpm - slow pulse <60 bpm - chest pressure or pain - shortness of breath  
palpitations/arrhythmia - high blood pressure - low blood pressure - flushed face - dizziness/vertigo  
fainting - phlebitis - varicose veins - cold hands and feet - cold sweats - poor circulation - blood clots  
bruise easily - other heart or blood vessel problems \_\_\_\_\_

**Gastro-intestinal:** poor appetite - always hungry - difficult or painful bowel movement - abdominal pain  
distention/bloating - ulcer - nausea - vomiting - vomiting with blood - acid reflux - lack of stomach acid  
foul breath - belching - intestinal gas - irritable bowel - diarrhea/loose stool - constipation - hard stool  
blood in stool - black stool - hemorrhoids - chronic laxative use - other \_\_\_\_\_

**Respiratory, Eye/Ear/Nose/Throat, Head:** chronic cough - coughing blood - asthma/wheezing  
bronchitis - pneumonia - tuberculosis - shortness of breath on exertion/at rest - difficulty breathing lying  
down - excessive phlegm - frequent colds - nose bleeds - chronic runny nose - chronic stuffy nose - post-  
nasal drip - sinus problems - painful/red eyes - poor vision - see spots - night blindness - blurry vision  
ear pain/infections - poor hearing - ringing in ears - sore throat - streptococci infections - bleeding gums  
sores on lips or tongue - gum problems - dental abscess - facial pain - TMJ /jaw pain - other \_\_\_\_\_  
frequent headaches/migraines describe \_\_\_\_\_

**Urinary:** frequent urination - painful urination - burning urination - blood in urine - trouble starting stream  
urgency to urinate - incontinence - urinary tract infections - kidney stones - pale urine - dark yellow urine  
Do you wake at night to urinate? \_\_\_\_\_ other \_\_\_\_\_

**Musculoskeletal:** arthritis/joint pain - tendonitis - rheumatism - repetitive strain - muscle pain  
where? \_\_\_\_\_  
pain is: sharp - burning - dull/aching - deep - superficial - tingling - better with heat - better with cold -  
better with rest - better with movement or massage - worse in a.m. or p.m.

**Women:** irregular menstruation - pain before / during / after menses - heavy / light / no bleeding - clots -  
spotting between periods - vaginal itching/burning or pain - PMS symptoms - yeast infection - breast lumps -  
breast tenderness - discharge from breasts - infertility - menopausal symptoms - reduced sexual energy  
genital sores - genital pain - other \_\_\_\_\_

**Men:** prostatitis - impotence - premature ejaculation - seminal emission - reduced sexual energy - genital  
sores - genital pain - penis blood/mucus discharge - vasectomy - other \_\_\_\_\_

**Misc:** anemia - fatigue/exhaustion - hypoglycemia - motion sickness - tremors - poor balance - fever - chills  
other \_\_\_\_\_

Is there anything else you'd like to add: \_\_\_\_\_

Thank you!