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Health History Questionnaire

Please help me to 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 any questions, please ask. Thank you for taking the time to fill this out form thoughtfully.

Name:_____ Age _____ Birth Date _____ Gender _____

Address_____ City_____ Zip_____

Mobile Phone_____ Work Phone_____ Work Phone_____

Emergency Contact _____ Phone_____

E-Mail:_____ Can we send you health newsletter via e-mail? Yes ☐ No ☐

Family Physician_____ Referred by_____

Current Health Concerns

Please list your health concerns. Begin with the most important to address today.
Classify your health concern as: **1=** Minor **2 =** Moderate **3 =** Fairly severe and getting worse **4 =** Serious

	Classified As	*Date of Onset*
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____

To What extent do these problems interfere with your daily activities (work, sleep, range of movement, sex)?
_____
_____

What kind of treatments have you tried? Acupuncture? Yes ☐ No ☐ other:_____
_____

Please list some of the most *notably* significant events in your life beginning with the most recent. (e.g. marriage/divorce, accidents, career change, deaths of loved ones, residency changes etc.)
1._____
2._____
3._____
4._____

What kind of concerns do you have regarding your current health situation? Check all that apply.
_____ 1. I would like to have relief from my symptoms or pain.
_____ 2. I would like to alleviate as much as possible the tendencies which cause my condition.
_____ 3. I would like to be holistically balanced as much as possible, including body, mind and spirit.
_____ 4. I would like "tune-up" or maintenance care to proactively keep in optimum health.

General Information

Yes	No		Yes	No	
☐	☐	Do you have diabetes?	☐	☐	Do you have hepatitis, cancer or HIV?
☐	☐	Do you bruise easily?	☐	☐	Have you recently traveled outside US?
☐	☐	Do you bleed for a long time from a cut?	☐	☐	Have you ever been treated for emotional problems
☐	☐	Do you have a tendency to faint?	☐	☐	Have you ever considered or attempted suicide?
☐	☐	Are you nervous about needles?	☐	☐	Do you have lymph edema?
☐	☐	Are you generally very tired?	☐	☐	
☐	☐	Do you have high blood pressure?	☐	☐	
☐	☐	Do you have a pacemaker or other electronic device in your body?	☐	☐	

Personal Health Habits

Yes **No**

☐ ☐ Smoker Smoked for _____ years. Smoke _____ pack(s) per day currently. If stopped, year: ____

☐ ☐ Alcohol Type_____ Frequency _____

☐ ☐ Recreational Drugs Type _____Frequency _____

☐ ☐ Coffee Cups per day _____ Water drink per day: _____

☐ ☐ Regular Exercise If so, describe type and frequency_____

Height _____ Current Weight _____ lbs.

Stress: What do you currently find most stressful?

_____

_____

Daily Diet: Please describe your average daily diet:

Morning_____

Lunch _____

Evening_____

Snacks _____

Sleep: How many hours per night? _____ Do you dream, if so how often? _____Nightmares?____

Do you fall asleep easily? Do you wake up often? **Yes** ☐ **No** ☐ Any specific time(s)?_____

Energy: Are you happy with your level of energy? **Yes** ☐ **No** ☐ My energy is highest at what time of day? _____

It is lowest at what time? _____ On a scale of 1-10, (10 very high) what is your energy? _____

Hospitalization/ Accidents

List any hospitalizations, surgery, serious injuries, any recent dental work with a short description and date.

_____

_____

_____

_____

Current & Former Conditions

☑ Check mark any of the following that you are experiencing now or have experienced in the past 3 months.

General Symptoms

- ☐ Headache or migraine
- ☐ Feel warmth a lot
- ☐ Feel cool a lot
- ☐ fatigue
- ☐ abnormal sweating
- ☐ dizziness/ tremors
- ☐ convulsions
- ☐ decreased motivation
- ☐ difficulty concentrating
- ☐ poor memory
- ☐ decreased libido
- ☐ night sweats
- ☐ poor balance
- ☐ edema Where?_____
- ☐ chills

Skin & Hair

- ☐ rashes
- ☐ itching
- ☐ change in hair or skin
- ☐ dry skin
- ☐ clammy skin
- ☐ hair loss
- ☐ other hair/skin problems

_____

Head, Ears, Nose & Throat

- ☐ facial pain
- ☐ glasses/ contacts
- ☐ floaters
- ☐ night blindness
- ☐ blurry vision
- ☐ eye pain
- ☐ eye strain
- ☐ cataracts
- ☐ eye dryness
- ☐ excessive tearing
- ☐ eye inflammation
- ☐ Discharge from eyes
- ☐ poor hearing
- ☐ ringing in ear
- ☐ earaches
- ☐ discharge form ears
- ☐ nasal congestion
- ☐ sneezing
- ☐ hay fever/ allergies
- ☐ asthma
- ☐ loss of taste
- ☐ recurrent sore throat
- ☐ nose bleeds
- ☐ TMJ
- ☐ tooth or gum problems
- ☐ teeth grinding
- ☐ frequent cold sores
- ☐ sores on lips or tongue

Respiratory

- ☐ cough
- ☐ pain with a deep breath
- ☐ difficulty breathing while lying down
- ☐ production of phlegm

  What color?_____
- ☐ coughing blood
- ☐ bronchitis
- ☐ other Lung problems:

_____

_____

Gastrointestinal

- ☐ bad breath
- ☐ nausea
- ☐ vomiting
- ☐ heartburn
- ☐ belching
- ☐ indigestion
- ☐ constipation
- ☐ chronic laxative use
- ☐ blood in stools
- ☐ black stools
- ☐ abdominal cramps or pain
- ☐ diarrhea
- ☐ gas
- ☐ rectal pain
- ☐ hemorrhoids
- ☐ other stomach or intestinal problems_____
- ☐ bloating

Cardio-Vascular

- ☐ high blood pressure
- ☐ low blood pressure
- ☐ chest discomfort or pain
- ☐ cold hands or feet
- ☐ swelling in: ☐ hands ☐ feet
- ☐ blood clots
- ☐ fainting
- ☐ palpitations
- ☐ irregular heartbeat

Genito-Urinary

- ☐ pain on urination
- ☐ urgency to urinate
- ☐ frequent urination
- ☐ blood in urine
- ☐ decrease in flow
- ☐ unable to hold urine
- ☐ dribbling
- ☐ kidney stones
- ☐ impotency
- ☐ sores on genitals
- ☐ wake to urinate.

  How often?_____
- ☐ history of STD's
- ☐ abundant pale urination

Musculoskeletal

- ☐ Joint Pain/ Stiffness

  (indicate specific areas on page 4)
- ☐ Muscle weakness
- ☐ Bone problems
- ☐ Arthritis

Neurological

- ☐ spasms
- ☐ numbness or tingling
- ☐ paralysis

Emotions

- ☐ irritability/anger
- ☐ depression
- ☐ anxiety
- ☐ Mood swings
- ☐ fear
- ☐ chronic worry
- ☐ excessive grief

Male Issues

- ☐ impotence/ fertility issues
- ☐ penile sores or discharges
- ☐ prostate enlargement
- ☐ erectile dysfunction
- ☐ excessive sexual activity
- ☐ low testosterone levels

Medications/Vitamins/Supplements

Please list all your medications or provide a list. Include sleeping pills, birth control agents and non-prescription drugs that you use on a regular basis (e.g. aspirin, laxatives, antihistamines, antacids).

_____
_____
_____
_____
_____

Please list all your vitamins and supplements you are taking on a regular basis.

_____
_____

Please list all herbs you are taking on a regular basis.

_____
_____

Family History:

☐ Cancer	☐ Heart Disease	☐ Mental Illness	☐ Thyroid disease
☐ Diabetes	☐ Stroke	☐ MS	☐ Glaucoma
☐ Hepatitis	☐ Seizures	☐ Asthma	☐ Tuberculosis
☐ High Blood Pressure	☐ Depression	☐ Autoimmune Disease	☐ Kidney disease

On a scale of 1-10 (1 is low 10 is high) please note the degree of severity of your problem now:	On a scale of 1-10 (1 is low 10 is high) please note the degree of severity of your problem a week ago:

Please indicate painful or distressed areas below.