

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 _____ Sex: M / F

Address _____ City _____ Zip Code _____

Evening Phone _____ Day 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.

Current & Former Conditions

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

General Symptoms	<input type="checkbox"/> eye inflammation <input type="checkbox"/> Discharge from eyes <input type="checkbox"/> poor hearing <input type="checkbox"/> ringing in ear <input type="checkbox"/> earaches <input type="checkbox"/> discharge form ears <input type="checkbox"/> nasal congestion <input type="checkbox"/> sneezing <input type="checkbox"/> Hay fever/ allergies <input type="checkbox"/> asthma <input type="checkbox"/> loss of taste <input type="checkbox"/> recurrent sore throat <input type="checkbox"/> nose bleeds <input type="checkbox"/> TMJ <input type="checkbox"/> tooth or gum problems <input type="checkbox"/> teeth grinding <input type="checkbox"/> frequent cold sores <input type="checkbox"/> sores on lips or tongue	<input type="checkbox"/> constipation <input type="checkbox"/> chronic laxative use <input type="checkbox"/> blood in stools <input type="checkbox"/> black stools <input type="checkbox"/> abdominal cramps or pain <input type="checkbox"/> diarrhea <input type="checkbox"/> gas <input type="checkbox"/> rectal pain <input type="checkbox"/> hemorrhoids <input type="checkbox"/> other stomach or intestinal Problems _____ <input type="checkbox"/> bloating	Musculoskeletal
<input type="checkbox"/> Headache or migraine <input type="checkbox"/> Feel warmth a lot <input type="checkbox"/> Feel cool a lot <input type="checkbox"/> fatigue <input type="checkbox"/> abnormal sweating <input type="checkbox"/> dizziness/ tremors <input type="checkbox"/> convulsions <input type="checkbox"/> decreased motivation <input type="checkbox"/> difficulty concentrating <input type="checkbox"/> poor memory <input type="checkbox"/> decreased libido <input type="checkbox"/> night sweats <input type="checkbox"/> poor balance <input type="checkbox"/> edema Where? _____ <input type="checkbox"/> chills			<input type="checkbox"/> Joint Pain/ Stiffness To indicate specific areas see page 4. <input type="checkbox"/> Muscle weakness <input type="checkbox"/> Bone problems <input type="checkbox"/> Arthritis
			Neurological
			<input type="checkbox"/> spasms <input type="checkbox"/> numbness or tingling <input type="checkbox"/> paralysis
			Emotions
			<input type="checkbox"/> irritability/anger <input type="checkbox"/> depression <input type="checkbox"/> anxiety <input type="checkbox"/> Mood swings <input type="checkbox"/> fear <input type="checkbox"/> chronic worry <input type="checkbox"/> excessive grief
Skin & Hair			Female Issues
<input type="checkbox"/> rashes <input type="checkbox"/> itching <input type="checkbox"/> change in hair or skin <input type="checkbox"/> dry skin <input type="checkbox"/> clammy skin <input type="checkbox"/> hair loss <input type="checkbox"/> other hair/skin problems _____			<input type="checkbox"/> pregnancies____ births____ <input type="checkbox"/> premature births <input type="checkbox"/> miscarriages <input type="checkbox"/> stillborn/ abortions_____ <input type="checkbox"/> first menses: age_____ <input type="checkbox"/> last PAP _____ <input type="checkbox"/> duration of menses <input type="checkbox"/> days between menses <input type="checkbox"/> painful menstrual periods <input type="checkbox"/> clots <input type="checkbox"/> excessive or light flow-circle <input type="checkbox"/> cramps or headaches <input type="checkbox"/> vaginal discharge <input type="checkbox"/> breast soreness
	Respiratory		
	<input type="checkbox"/> cough <input type="checkbox"/> pain with a deep breath <input type="checkbox"/> difficulty breathing while lying down <input type="checkbox"/> Production of phlegm What color? _____ <input type="checkbox"/> coughing blood <input type="checkbox"/> bronchitis <input type="checkbox"/> other Lung problems: _____ _____		
		Cardio-Vascular	
		<input type="checkbox"/> high blood pressure <input type="checkbox"/> low blood pressure <input type="checkbox"/> chest discomfort or pain <input type="checkbox"/> cold hands or feet <input type="checkbox"/> swelling in: <input type="checkbox"/> hands or <input type="checkbox"/> feet <input type="checkbox"/> blood clots <input type="checkbox"/> fainting <input type="checkbox"/> palpitations <input type="checkbox"/> irregular heartbeat	
			Male Issues
		Genito-Urinary	<input type="checkbox"/> impotence/ fertility issues <input type="checkbox"/> penile sores or discharges <input type="checkbox"/> prostate enlargement
Head, Ears, Nose & Throat			
<input type="checkbox"/> facial pain <input type="checkbox"/> glasses/ contacts <input type="checkbox"/> floaters <input type="checkbox"/> night blindness <input type="checkbox"/> blurry vision <input type="checkbox"/> eye pain <input type="checkbox"/> eye strain <input type="checkbox"/> cataracts <input type="checkbox"/> eye dryness <input type="checkbox"/> excessive tearing		<input type="checkbox"/> pain on urination <input type="checkbox"/> urgency to urinate <input type="checkbox"/> frequent urination <input type="checkbox"/> blood in urine <input type="checkbox"/> decrease in flow <input type="checkbox"/> unable to hold urine <input type="checkbox"/> dribbling <input type="checkbox"/> kidney stones <input type="checkbox"/> impotency <input type="checkbox"/> sores on genitals <input type="checkbox"/> wake to urinate. How often? _____ <input type="checkbox"/> history of STD's <input type="checkbox"/> abundant pale urination	
	Gastrointestinal		
	<input type="checkbox"/> bad breath <input type="checkbox"/> nausea <input type="checkbox"/> vomiting <input type="checkbox"/> heartburn <input type="checkbox"/> belching <input type="checkbox"/> indigestion		

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:

<input type="checkbox"/> Cancer	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Mental Illness	<input type="checkbox"/> Thyroid disease
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Stroke	<input type="checkbox"/> MS	<input type="checkbox"/> Glaucoma
<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Seizures	<input type="checkbox"/> Asthma	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Depression	<input type="checkbox"/> Autoimmune Disease	<input type="checkbox"/> Kidney disease

Please note the degree of severity of your problem now:

0	1	2	3	4	5	6	7	8	9	10
Lowest Highest										

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

0	1	2	3	4	5	6	7	8	9	10
Lowest Highest										

Please indicate painful or distressed areas below.

