HEALTH HISTORY

This is a **CONFIDENTIAL** questionnaire to help us determine the best treatment plan for you.

Name _____ Date _____

Home Address _____ City _____

State __ Zip_____ Email _____ Home Phone _____Work _____

Occupation _____ Person responsible for your account _____

Emergency Contact _____ Phone _____

Who can we thank for referring you? _____

Sex: M____F____ Height: ____ Weight: _____ Birth Date: _____ Age: _____

Marital Status: □ Married □ Single □ Divorced □ Widowed Number of children: _____

Previous Acupuncture? Y or N When?_____ With whom? _____

Please circle yes or no (leave blank if uncertain) any significant illnesses you or a blood relative (parent, grandparent or sibling) have had:

			Relationship				**Relationship**
Cancer	N	Y	_____	Diabetes	N	Y	_____
Hepatitis	N	Y	_____	Heart Disease	N	Y	_____
High blood pressure	N	Y	_____	Seizures	N	Y	_____
Rheumatic Fever	N	Y	_____	Tuberculosis	N	Y	_____
Emotional Disorders	N	Y	_____	Stroke	N	Y	_____
Infectious Diseases	N	Y	_____	High Cholesterol	N	Y	_____
Obesity	N	Y	_____	Migraines	N	Y	_____
Drug/Alcohol Problems	N	Y	_____	Asthma	N	Y	_____

Sexually Transmitted Diseases: gonorrhea □ syphilis □ HIV □ HPV □ chlamydia □ herpes □ Date:_____

Please circle with a yes or no the use and frequency of the following:

			Amount				**Amount**
Coffee/Black Tea	N	Y	_____	Tobacco	N	Y	_____
Recreational drugs	N	Y	_____	Water Intake	N	Y	_____
Alcohol	N	Y	_____	Soda	N	Y	_____

Please circle no or yes to the following statements:

I have known allergies	N	Y
I am taking Coumadin/Warfarin	N	Y
I have a pacemaker	N	Y
I am taking Lithium (Eskalith, Lithoid, Lithonate, Lithotabs)	N	Y

List all medications and supplements you are currently taking:
(Continue on back if needed)

Medicine	Dosage	Reason	How Long	Prescribed by	Date last checkup

What are the main health problems for which you are seeking treatment?
_____
_____
_____

What other forms of treatment have you sought?_____
_____

List any other health problems you now have._____
_____
_____
_____

List any allergies (foods, drugs, food sensitivities or food cravings that you have._____
_____
_____
_____

List any accidents, surgeries, or hospitalizations (include date). ____
_____
_____

Practitioner's Use Only

□ Onset □ Location □ Duration □ Characteristics
□ Aggrevate/Allev □ Related Factors □Treatment □ Significance

How do you feel about the following areas of your life?
Check the appropriate boxes and indicate any problems you may be experiencing

	Great	Good	Fair	Poor	Bad	Your Comments
Significant other	□	□	□	□	□	_____
Family	□	□	□	□	□	_____
Diet	□	□	□	□	□	_____
Sex	□	□	□	□	□	_____
Self	□	□	□	□	□	_____
Work	□	□	□	□	□	_____
Exercise	□	□	□	□	□	_____
Spirituality	□	□	□	□	□	_____

FOR WOMEN

Age of 1st period (menarche)_____ Are you Pregnant? Y or N # of pregnancies_____
Age of last period (menopause) _____ # of live births_____ # of Abortions_____
# of Miscarriages_____
Date of last: gynecological exam: _____ Pap Smear ___ Mammogram_____ Bone Scan_____
Include results:_____
# of Days between periods:_____ # of days of flow: _____ Color of flow: _____
Average # of pads/tampons used per day: 1st day _____ 2nd day ____3rd day4th day _____+days__
Have you been diagnosed with: fibroids □ Fibrocystic Breasts □ Endometriosis □ Ovarian Cysts □ PID □ Other _____
Location of Pain: Lower abdomen □ Lower back □ Thighs □ Other □_____
Nature of Pain: (please indicate before, during, or after menses)
Cramping_____ Stabbing _____
Burning _____ Aching _____
Dull _____ Bloating _____
Consistent _____ Intermittent_____
Bearing down sensation _____

Other Symptoms related to menses
□Discharge □ Vaginal dryness □ Headache
□Nausea □ Constipation □ Diarrhea
□ Swollen breasts □ Mood Swings □ Insomnia
□ Ravenous appetite □ Poor appetite
□ Hot flashes □ Night sweats □ Increased libido
□ Decreased libido

FOR MEN

Date of last prostate check up _____ PSA results _____ Manual prostate exam results _____
Lab results _____
Frequency of Urination: daytime _____ nighttime _____ Color of urine: clear □ murky □ odor: _____
Symptoms related to prostate
□ Prostate problems □ Delayed stream □ Dribbling □ Incontinence
□ Retention of urine □ Rectal dysfunction □ Increased libido □ Decreased libido
□ Premature ejaculation □ Impotence □ Back pain □ Groin pain
□ Testicular pain other _____

SYMPTOM SURVEY (For Everyone)

The following is a list of symptoms that you may or may not ever experience.
Please indicate as follows:
no mark = never experience **check mark** (√)**=** sometimes experience **Plus sign** (+) **=** frequently experience

_____lack of appetite
_____excessive appetite
_____loose stools or diarrhea
_____digestive problems, indigestion
_____vomiting
_____belching, burping
_____heartburn, reflux
_____feeling of retention of food in the stomach
_____tendency to become obsessive in work, relationships…

_____insomnia, difficulty sleeping
_____heart palpitations
_____cold hands and feet
_____nightmares
_____mentally restless
_____laughing for no apparent reason
_____angina pains

_____abdominal pain
_____chest pain
_____sciatic pain
_____headaches
_____pain or coldness in genital area

_____cough
_____shortness of breath
_____decreased sense of smell
_____nasal problems
_____skin problems
_____feeling of claustrophobia
_____bronchitis
_____colitis or diverticulitis
_____constipation
_____hemorrhoids
_____recent use of antibiotics

_____eye problems
_____jaundice (yellowish eyes or skin)
_____difficulty digesting oily foods
_____gall stones
_____light colored stool
_____soft or brittle nails
_____easily angered or agitated
_____difficulty in making plans or decisions
_____spasms or twitching

_____low back pain
_____knee problems
_____hearing impairment
_____ear ringing
_____kidney stones
_____decreased sex drive
_____hair loss
_____urinary problems

_____fatigue
_____edema
_____blood in stool
_____black tarry stool
_____easily bruised
_____difficult to stop bleeding
_____asthma
_____tendency to catch colds easily
_____intolerance to weather changes
_____allergies
_____hay fever
_____dizziness
_____tendency to faint easily
_____high cholesterol levels
_____sudden weight loss

Please answer the following questions if you have PAIN:

describe location:_____
_____

quality of pain:(circle) dull sharp stabbing sore cramping throbbing burning
constant radiating fixed moves about severe moderate

pain radiates to:_____

describe the onset of the pain:_____
_____

helps pain (circle): ice heat rest movement am p.m. dampness dry
aggravates(circle): ice heat rest movement am p.m. dampness dry

Are there any movements that aggravate the pain (list)_____
_____

How does exercise affect your pain_____

Do any medications help your pain_____

Other treatments you've had for the pain_____