HEALTHY COMMUNITY ACUPUNCTURE

Health History Questionnaire

Name ______________________________ Age______ Phone ____________ DOB ____/_____/______

Address ____________________________ City/State/Zip_________________ Email _______________

Who Referred You? ___________________________ Occupation ________________________________

Height _______ Current Weight ______ lb. Maximum Weight ______ lb. When? ____________

What condition(s) are your primary concerns in coming for treatment?

1)

2)

3)

Family History:
Please fill in the age and health information for family members. Place a checkmark where they have an applicable history.

	Father	Mother	Brothers	sisters	Child	spouse
Health (G=good; P=poor)						
Age, if living						
If deceased, age at death						
Cancer						
Diabetes						
Heart Disease						
High Blood Pressure						
Stroke						
Epilepsy						
Mental Illness						
Asthma, hay fever, hives						
Anemia						
Kidney Disease						
Glaucoma						
Tuberculosis						

Childhood Illnesses: When? ______

Scarlet Fever	Yes	No
Mumps	Yes	No
Chicken Pox	Yes	No
Diphtheria	Yes	No
Measles	Yes	No
Pneumatic fever	Yes	No
German Measles	Yes	No
Pertussis	Yes	No
Polio	Yes	No
Diphtheria	Yes	No
Other	Yes	No

Immunizations:

Measles/Mumps/Rubella	Yes	No
Tetanus	Yes	No

Allergies:
Are you hypersensitive or allergic to:
Any Drugs? ☐ Yes ☐ No Please List:

____

____

Any Foods? ☐ Yes ☐ No Please List:

____

____

Current Medications:
Please list any prescription medications, over the counter medications, vitamins, or other supplements you are currently taking:

____

____

Symptom Profile:
For the following, please check **YES** for a condition you have **currently** and check **PAST** for a condition you've had in the past, noting the date in the space provided.

Skin disorders:

Currently Have?	**■YES**	**■PAST**	**When?**
Acne, Boils	☐	☐	___________
Acute Hair Loss	☐	☐	___________
Color Change	☐	☐	___________
Eczema, Hives	☐	☐	___________
Itching	☐	☐	___________
Nail Fungus	☐	☐	___________
Psoriasis	☐	☐	___________
Rash	☐	☐	___________
Other___________	☐	☐	___________

Respiratory System Disorders:

Currently Have?	**■YES**	**■PAST**	**When?**
Bronchitis	☐	☐	___________
Chronic Asthma	☐	☐	___________
Chronic Cough	☐	☐	___________
Emphysema	☐	☐	___________
Frequent Colds	☐	☐	___________
Pain in Breathing	☐	☐	___________
Pleurisy	☐	☐	___________
Pneumonia	☐	☐	___________
Shortness of Breath	☐	☐	___________
Sinus Congestion	☐	☐	___________
Spitting Up Blood	☐	☐	___________
Temporary Cough	☐	☐	___________
Tuberculosis	☐	☐	___________
Nasal Drainage to Throat	☐	☐	___________
Other___________	☐	☐	___________

Emotional or Mental Illness:

Currently Have?	**■YES**	**■PAST**	**When?**
Anxiety	☐	☐	___________
Depression	☐	☐	___________
Considered or Attempted Suicide	☐	☐	___________
Irritability	☐	☐	___________
Mood Swings	☐	☐	___________
Other___________	☐	☐	___________

Head, Ear, Eyes, Nose, Throat:

Currently Have?	**■YES**	**■PAST**	**When?**
Head:			
Headaches	☐	☐	___________
Migraines	☐	☐	___________
Head Injury	☐	☐	___________
Hay Fever	☐	☐	___________
Ears:			
Earaches	☐	☐	___________
Ringing in Ears	☐	☐	___________
Impaired Hearing	☐	☐	___________
Dizziness	☐	☐	___________
Eyes:			
Cataracts	☐	☐	___________
Color Blindness	☐	☐	___________
Contacts or Glasses	☐	☐	___________
Double Vision	☐	☐	___________
Eye Pain or Strain	☐	☐	___________
Glaucoma	☐	☐	___________
Impaired Vision	☐	☐	___________
Tearing or Dryness	☐	☐	___________
Spots in Front of Eyes	☐	☐	___________
Nose:			
Nose Bleeds	☐	☐	___________
Loss of Smell	☐	☐	___________
Mouth:			
Bleeding Gums	☐	☐	___________
Dental Cavities	☐	☐	___________
Dry Mouth	☐	☐	___________
Oral Sores	☐	☐	___________
Oral Thrush	☐	☐	___________
Teeth Grinding	☐	☐	___________
Jaw Problems, TMJ	☐	☐	___________

Throat:	**■YES**	**■PAST**	**When?**
Goiter	□	□	___________
Hoarseness	□	□	___________
Swollen Glands	□	□	___________
Trouble Swallowing	□	□	___________
Neck Pain/Stiffness	□	□	___________
Frequent Sore Throat	□	□	___________
Other___________	□	□	___________

Digestive System Disorders:

Currently Have?	**■YES**	**■PAST**	**When?**
Nausea	□	□	___________
Vomiting	□	□	___________
Loss of Appetite	□	□	___________
Ulcer	□	□	___________
Heartburn	□	□	___________
Gas or Bloating	□	□	___________
Internal Cramping	□	□	___________
Constipation	□	□	___________
Diarrhea	□	□	___________
Loose Stool	□	□	___________
Hemorrhoids	□	□	___________
Bowel Movement Frequency? _______________			
- Is this a change?	□	□	___________
Other___________	□	□	___________

Cardiovascular Disorders:

Currently Have?	**■YES**	**■PAST**	**When?**
Heart Disease	□	□	___________
Endocarditis	□	□	___________
Chest Pain	□	□	___________
Heart Murmur	□	□	___________
Palpitations or Fluttering	□	□	___________
High Blood Pressure	□	□	___________
Low Blood Pressure	□	□	___________
Phlebitis	□	□	___________
Blood Clots	□	□	___________
Ankle Swelling	□	□	___________
Fainting	□	□	___________
Other___________	□	□	___________

Urinary Tract Disorders:

Currently Have?	**■YES**	**■PAST**	**When?**
Frequent Infection	□	□	___________
Frequent Night Urination	□	□	___________
Inability to Hold Urine	□	□	___________
Burning or Pain During Urination	□	□	___________
Increased Frequency	□	□	___________
Kidney Stones	□	□	___________
Other___________	□	□	___________

Musculoskeletal Disorders:

Currently Have?	**■YES**	**■PAST**	**When?**
Weakness	□	□	___________
Muscle Spasms or Cramps	□	□	___________
Joint Pain, Swelling, or Stiffness			
Sciatica	□	□	___________
Fibromyalgia	□	□	___________
Broken Bones	□	□	___________
Any Other Pain	□	□	___________
Location: ______________________________			
Other ___________	□	□	___________

Miscellaneous:

Currently Have?	**■YES**	**■PAST**	**When?**
Easy Bleeding or Bruising	□	□	___________
Varicose Veins	□	□	___________
Anemia	□	□	___________
Slow Wound Healing	□	□	___________
Chronic Infections	□	□	___________
Day Sweats	□	□	___________
Night Sweats	□	□	___________
Cold Hands or Feet	□	□	___________
Heat or Cold Intolerance	□	□	___________
Fatigue	□	□	___________
Chronic Fatigue Syndrome			
Hypoglycemia	□	□	___________
Hyperthyroid	□	□	___________
Excessive Thirst	□	□	___________
Excessive Hunger	□	□	___________
Diabetes	□	□	___________
Gallbladder Disease	□	□	___________
Liver Disease	□	□	___________
Jaundice	□	□	___________
Hepatitis	□	□	___________
- Type? ________________________________			
Other___________	□	□	___________

Lifestyle Habits:

Do You….	**■ No**	**■ Yes**
Exercise?	□ No	□ Yes
What Kind? ______________		
How Often? ______________		
Take Vacations?	□ No	□ Yes
How Often? ______________		

Sleep Habits:

Do You….	**■ No**	**■ Yes**
Sleep Well?	□ No	□ Yes
Awaken Rested?	□ No	□ Yes
Average 6-8 Hours Sleep?	□ No	□ Yes
Spend Time Outside?	□ No	□ Yes

What time of day is your energy at its best?

____

Tobacco, Food and Drink Habits:

Do you…	**■ No**	**■ Yes**
Use Tobacco?	□ No	□ Yes
How Much/How often? ______________		
Smoked Previously?	□ No	□ Yes
How Long? ______________		
How many packs per day? ______________		
Ever been treated for drug dependence?	□ No	□ Yes
Drink Alcohol?	□ No	□ Yes
How much? ______________		
Drink Caffeinated Beverages?	□ No	□ Yes
How often? ______________		
Eat out often?	□ No	□ Yes
How many times per week? ______________		
How many meals do you eat per day? ______________		
Go on diets often?	□ No	□ Yes

Typical Food Intake:

Breakfast ______________

Lunch ______________

Dinner ______________

Snacks______________

Any History of Psychological, Physical or Sexual Abuse? □ No □ Yes ______________

____

FOR MEN ONLY:

Do you now, or have you ever had…?			**When?**
Testicular Masses	□ No	□ Yes	______
Testicular Pain	□ No	□ Yes	______
Prostate Disease	□ No	□ Yes	______
Impotence	□ No	□ Yes	______
Premature Ejaculation	□ No	□ Yes	______
Hernias	□ No	□ Yes	______
Condyloma	□ No	□ Yes	______
Syphilis	□ No	□ Yes	______
Genital, Oral or Rectal Herpes	□ No	□ Yes	______
Gonorrhea	□ No	□ Yes	______
Other ______	□ No	□ Yes	______

FOR WOMEN ONLY:

Do you now, or have you ever had…?			**When?**
Breast Lumps	□ No	□ Yes	______
Nipple Discharge	□ No	□ Yes	______
Breast Pain or Tenderness	□ No	□ Yes	______
Abnormal PAP Smear	□ No	□ Yes	______
Cervical Dysplasia	□ No	□ Yes	______
Vaginal Discharge	□ No	□ Yes	______
Gonorrhea	□ No	□ Yes	______
Syphilis	□ No	□ Yes	______
Genital, Oral or Rectal Herpes	□ No	□ Yes	______
Condyloma	□ No	□ Yes	______
Fibroids	□ No	□ Yes	______
Ovarian Cysts	□ No	□ Yes	______
Sexual Difficulties	□ No	□ Yes	______
Are you sexually active?	□ No	□ Yes	______
Are you on birth control?	□ No	□ Yes	______
Number of Pregnancies			______
Number of Live Births			______
Number of Miscarriages			______
Number of Abortions			______
Age at first menses			______
Length of cycle in days			______
Duration of period in days			______
PMS Symptoms	□ No	□ Yes	______
Painful Menses	□ No	□ Yes	______
Clotting during menses	□ No	□ Yes	______
Bleeding between periods	□ No	□ Yes	______
Menopausal symptoms	□ No	□ Yes	______
Other ______	□ No	□ Yes	______