Initial Visit Date: _____

Health History Questionnaire

Please help us provide you with a complete evaluation by taking the time to fill out this questionnaire carefully. All your answers will be held absolutely confidential. If you have questions, please ask. If there is anything you wish to bring to our attention which is not asked on this form, please note it in the Comments section. Thank you.

Name:	Date and Place of Birth:
Street:	City/State/Zip:
Age: Height: Weight: Marital Status:	Home phone:
Work phone:	Cell phone:
Occupation:	Email address:
Family Physician	Referred to us by:
In Emergency Notify:	Emergency Contact Phone #:
Insurance Carrier:	Policy #:

Have you tried acupuncture or Chinese traditional herbal medicine before? _____

Main problem(s) you would like help with: _____

_____

To what extent does this problem affect your daily activities (work, sleep, eating, etc.)? _____

_____

How long has it been since you first noticed your symptoms? _____

_____

Have you been given a diagnosis for the problem? If so, what? _____

_____

What kinds of treatment have you tried? _____

_____

Past Medical History (please include month/year):

Significant Illness(es):

Cancer:	Diabetes:	Hepatitis:	High Blood Pressure:
Heart Disease:	Seizures:	Rheumatic Fever:	Thyroid Disease:

Surgeries: _____

_____

Significant Trauma: _____

_____

Your Birth History (prolonged labor, forceps delivery, etc.) _____

Allergies: _____

Other relevant medical history: _____

_____

Family Medical History:

Diabetes	Cancer	High Blood Pressure	Stroke
Heart Disease	Seizures	Asthma	Allergies

Other: _____

Medicines taken within the last two months (vitamins, drugs, herbs, etc.): _____

_____

COVID-19 Status:	Partial Vaccination ☐	Full Vaccination ☐	Booster Vaccine(s) ☐	*Circle:* Pfizer Moderna J&J	No Vaccine ☐	Contracted COVID-19: Date(s)

Occupational Stress Factors (physical, psychological, chemical, etc.): _____

_____

Do you follow a regular exercise program? _____ If so, please describe: _____

_____

Please describe your average daily diet:

Morning:	Afternoon:	Evening:

Do you smoke? _____ Packs per day _____.

How much coffee, tea or cola do you drink per week? _____

Are any of those "diet" drinks (aspartame/Nutrasweet, sucralose/Splenda, Saccharin, Stevia)? Yes _____ No _____

What kind of water do you drink? (bottled, tap, filtered, reverse osmosis, distilled, well) _____

Please check if you have had (in the last three months):

GENERAL

Poor Appetite		Poor Sleeping		Poor Balance	
Localized Weakness		Strong Thirst (__cold ___ hot drinks)		Night sweats	
Sudden energy drop (time of day _____)		Weight loss ____ Weight gain ____		Day Sweats	
Bleed ____ Bruise ___ easily		Sweat easily		Cravings	
Tremors		Chills		Fever	

MUSCULOSKELETAL

Neck Pain		Muscle Pains		Knee Pain	
Back Pain		Muscle Weakness		Foot/Ankle Pain	
Hand/Wrist Pain		Shoulder Pain		Hip Pain	

Any other joint or bone problems? _____

NEUROPSYCHOLOGICAL

Seizures		Dizziness		Loss of Balance	
Areas of Numbness:		Lack of Coordination		Poor Memory	
Concussion		Depression		Anxiety	
Easily Irritable		Easily Susceptible to Stress			

Have you ever been treated for emotional problems? _____
Have you ever considered or attempted suicide? _____
Any other neurological or psychological concerns? _____

HEAD, EYES, EARS, NOSE AND THROAT

Dizziness		Concussions		Migraines	
Glasses: ___near ___ far ___ astigmatism		Spots in Front of Eyes		Eye Pain	
Poor Vision		Night Blindness		Color Blindness	
Cataracts		Blurry/Cloudy Vision		Earaches	
Ringing in the Ears: ___high pitch ___ low pitch		Poor Hearing		Eyestrain	
Sinus Problems		Recurrent Sore Throats		Nose Bleeds	
Grinding Teeth ____ Clenching Teeth ____		Sores on Lips or Tongue		Facial Pain	
Dental Problems		Headaches: _____ what part of head _____ when do they occur		Jaw Clicks	

Any other head or neck concerns? _____

_____

RESPIRATORY

Cough ____ Dry _____ Mucus/Phlegm		Coughing Blood		Asthma	
Bronchitis		Pain with Deep Breath			
Pneumonia		Difficult Breathing on lying down			
Production of Phlegm _____ Color?					

Any other lung or respiratory concerns? _____

_____

CARDIOVASCULAR

High Blood Pressure		Low Blood Pressure		Chest Pain	
Irregular Heart Beat		Blood Clots		Fainting	
Cold Hands		Cold Feet		Phlebitis	
Swelling of Hands		Swelling of Feet/Ankles		Difficulty Breathing	

Any other heart or blood vessel issues? _____

GASTROINTESTINAL

Nausea		Vomiting		Diarrhea/ Loose Bowel Movements	
Constipation/ Dry or Hard Bowel Movements		Gas		Belching	
Black Stools		Blood in Stools		Indigestion	
Bad Breath		Rectal Pain		Hemorrhoids	
Abdominal Pain ____ Cramps _____		Chronic Laxative Use			

Any other problems with your stomach or intestines? _____

_____

GENITO-URINARY

Pain on Urination		Frequent Urination		Blood in Urine	
Urgency to Urinate		Difficulty Holding Urine/ Leaking		Kidney Stones	
Decrease in Flow		Decreased Libido		Sores on Genitals	

Do you wake up at night to urinate? _____ How often/ What time(s)? _____
Any particular color ot your urine? _____
Any other problems with your genital, reproductive or urinary systems? _____

_____

REPRODUCTIVE AND GYNECOLOGICAL
Do you practice birth control? _____ What type? _____ For how long? _____

(Women Only)

Number of Pregnancies		Number of Births		Premature Births	
Miscarriages		Age at First Menses		Abortion(s)	
Length of Time Between Menses		First Date of Last Menses		Duration of Menses	
Unusual Character ____ Heavy ____ Light		Clots		Painful Menstruation	
Irregular Menstruation		Last PAP		Vaginal Discharge	
Vaginal Sores		Breast Lumps		Menopause (age _____)	
Changes in body/psyche prior to or during menses:					

SKIN AND HAIR

Rashes		Ulcerations		Hives	
Itching		Eczema		Pimples	
Dandruff		Loss of Hair		Recent Moles or Changes	
Change in Hair or Skin Texture					

Any other hair or skin issues? _____

_____

COMMENTS
Are there other problems or concerns that have not yet been mentioned and/or require greater detail? _____

_____

In filling out this form, I understand that my practitioner will describe the means and methods by which available technologies provided may influence and support my care, and that further explanation is available on paper and/or via the practitioner's website.

_____
Patient Signature