



The Center for Integrative Healthcare & Healing

Acupuncture Health History Questionnaire

Date ___/___/___

Please help me provide you 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. If there is anything you wish to bring to my attention that is not included in this form please note it in the comments section on the last page. Thank you.

Personal Information

Name:		Social Security Number (optional)	
Address:	City:	State:	Zip Code:
Home Phone ()	Work Phone: () Ext.	Cell Phone: ()	Age:
Date of Birth: / /	City and State of Birth	Sex: Male ___ Female ___	
Height:	Weight:	Marital Status:	
Occupation:	Employer Name:	Family Physician:	
Referred By:	Emergency Contact:	Emergency Contact Phone: ()	
E-mail address			
Where may we contact you? Home / Work / Cell What is the best time to reach you?		Have you ever been treated with acupuncture or oriental medicine before?	

What's Bothering You?

What is/are the main problem(s) you would like me to help you with?

How long ago did this problem begin (be specific):

To what extent does this problem interfere with your daily activities (work, sleep, sex etc.)? :

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

What other kinds of treatment have you tried?

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Medical History

Please indicate date of disease

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

Surgeries (type and date):

Significant Trauma (auto accidents, falls etc.):

Significant Dental Work (type and date):

Birth History (prolonged labor, forceps delivery, etc.):

Allergies (drugs, chemicals and foods. Type of reaction):

Family Medical History: Put an "x" next to all that apply

Diabetes	High Blood Pressure	Stroke	Asthma
Cancer	Heart Disease	Seizures	Allergies
Other:			

Medicines taken within the last two months (including: vitamins, drugs, herbal remedies etc.):

Occupational Stress (physical, psychological, chemical etc.)

Other Stress: (Family/Home/Relationships)

Do you have a regular exercise program? Yes or No Please describe:

Have you ever been on a restricted diet? Yes or No What kind?

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Medical History Cont'd

Please put an "x" next to all symptoms you have had in the last 6 months.

General:

Chills
Fevers
Sweat easily
Night sweats
Localized weakness
Bleed or bruise easily
Peculiar tastes or smells
Thirst for cold drinks
Thirst for warm drinks

Head, Eyes, Ears, Nose and Throat:

Dizziness
Migraines
Headaches
 When:
 Where:
Facial Pain
Glasses
Poor vision
Night blindness
Blurry vision
Color blindness
Blind field
Spots in front of eyes
Eye pain
Eye strain
Excessive tearing
Discharge from eyes
Poor hearing
Ringing in ears
Earaches
Discharge from ear
Nose bleeds
Sinus congestion
Nasal drainage
Grinding teeth
Jaw clicking
Concussions
Recurrent sore throat
Hoarseness
Sores on lips or tongue
Other head or neck problems:

Skin and Hair:

Rashes
Itching
Hives
Change in hair of skin
Ulceration's
Eczema
Oozing skin lesion
Pimples
Recent moles
Change in shape or coloration of moles
Loss of hair
Dandruff

Respiratory:

Cough
Asthma / wheezing
Pain with a deep breath
Difficulty breathing when lying down
Production of phlegm
 What color?
Coughing blood
Pneumonia
Bronchitis
Other lung problems:

Cardiovascular:

High Blood Pressure
Low Blood Pressure
Chest discomfort / pain
Heart palpitations
Cold hands or feet
Swelling of hands
Swelling of feet
Blood clots
Fainting
Difficulty breathing
Other heart or blood vessel problems:

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Medical History Cont'd

Gastrointestinal:

- Bad breath
- Nausea
- Vomiting
- Heartburn
- Belching
- Indigestion
- Diarrhea
- Constipation\Chronic laxative use
- Blood in stools
- Black stools
- Abdominal pain or cramps
- Gas
- Rectal pain
- Hemorrhoids
- Other stomach or intestinal problems:

Genital-Urinary:

- Pain when urinating
- Urgency to urinate
- Frequent urination
- Blood in urine
- Decrease in flow
- Unable to hold urine
- Dribbling
- Kidney stones
- Impotency
- Change in sex drive
- Sores on genitals
- Do you wake up to urinate? Y or N
- If yes, how often?
- What time of night?
- Any particular color to your urine?
- Other genital or urinary system problems:

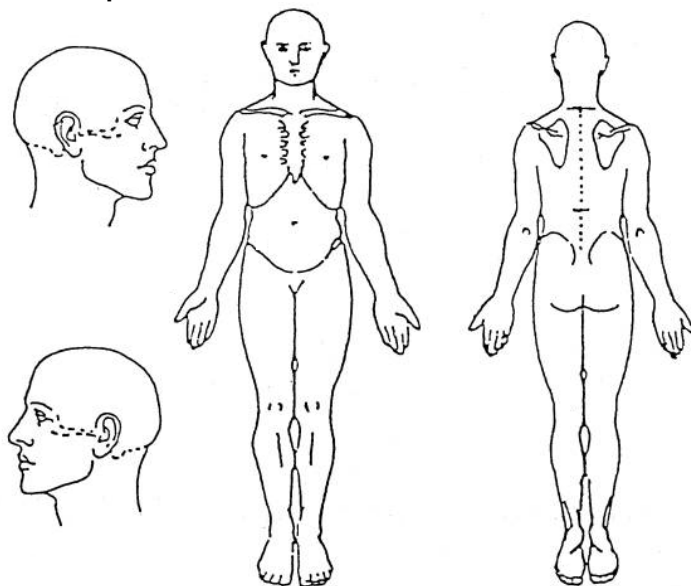
Musculoskeletal:

- Neck pain
- Shoulder pain
- Back pain
- Elbow pain
- Hand / wrist pain
- Hip pain
- Knee pain
- Foot / ankle pain
- Muscle pain
- Muscle weakness

Neuro-psychological

- Seizures
- Areas of numbness
- Weakness
- Sleep disorder
- Concussion
- Bad temper
- Loss of control / violence potential
- Vertigo
- Lack of coordination
- Depression
- Easily susceptible to stress
- Loss of balance
- Poor memory
- Anxiety
- Substance abuse
- Have you ever been treated for emotional problems?
- Have you ever considered suicide?
- Have you ever attempted suicide?

Indicate painful or distressed areas:



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Medical History Cont'd

On a scale of 0 to 10 (no problem to excruciating), please rate the degree of severity of your main complaint now:

On a scale of 0 to 10, please rate the greatest degree of severity of your problem within the last week:

WOMEN ONLY:

Regular menstrual cycle? Y or N

Pregnant? Y or N

Number of children:

Number of pregnancies:

Age of first menstruation:

Age of menopause (if applicable):

Average number of days of flow:

Average number of days of entire cycle:

Vaginal discharge? Y or N

Bleeding between periods? Y or N

Do you experience any of the following pre-menstrual syndromes? Put an "x" next to all that apply.

Nausea	Vomiting	Water retention	Breast swelling
Food cravings	Headaches	Migraines	Breast tenderness
Depression	Irritability	Anxiety	
Dull pain? Where		Sharp pain? Where	
Other emotions			

Please fill in the following menstrual chart:

	Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7
Color (normal, bright red, pale, brown, rust, dark, purple, other)							
Amount of flow (normal, heavy, light)							
Pain/cramps (location, dull, sharp, other)							
Clots (large, small, black, purple, red, other)							
Vomiting (check if yes)							
Nausea (check if yes)							
Other							

MEN ONLY

Do you experience any of the following symptoms? Put an "x" next to all that apply.

Swollen testes	Testicular pain	Impotence	Premature ejaculation
Feeling of coldness or numbness in external genitalia		Other	

Other Comments:

Thank you. Please print this document and bring to your appointment

Patient Signature: _____

Acupuncturist Signature: _____