Health Questionnaire

Please complete the information below. Answer the questions as thoroughly as possible to ensure the best possible care for your condition(s). Thank you!

All information is strictly confidential.

GENERAL PATIENT INFORMATION

Name _____ Date _____

Address _____ City _____

State _____ Zip _____ Date of birth _____ Place of birth _____

Home phone _____ Cell phone _____ Work phone _____

Gender: ☐ M ☐ F Age _____ Height _____ Weight _____ lbs.

Guardian (if under age 18) _____

EMERGENCY CONTACT

Name _____ Phone _____ Relationship _____

EMPLOYMENT & REFERRAL

Occupation _____ Employer _____

Employer address _____

How did you hear about us? _____

PRIMARY CARE PHYSICIAN

Physician name _____ Phone _____

Physician address _____

MEDICATIONS, SUPPLEMENTS & ALLERGIES

Current medications (include dates prescribed and dosage):

_____

_____

_____

Results of medications (include any side effects you have experienced during treatment):

_____

_____

Current supplements (if any; include vitamins, herbs, minerals, etc.):

_____

_____

Allergies to medications or other substances (e.g., latex) _____

PAST MEDICAL HISTORY

Check all that apply:

- ☐ ADD/ADHD
- ☐ AIDS/HIV
- ☐ Alcoholism/Substance abuse
- ☐ Allergies (seasonal)
- ☐ Asthma
- ☐ Autism/Asperger's
- ☐ Cancer: _____
- ☐ Diabetes ☐ Type 1 ☐ Type 2
- ☐ Emphysema
- ☐ Heart disease
- ☐ Hepatitis ☐ A ☐ B ☐ C
- ☐ Herpes ☐ 1 ☐ 2
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ High fever
- ☐ Jaundice
- ☐ Lyme disease
- ☐ Measles
- ☐ Migraines
- ☐ Multiple sclerosis
- ☐ Mumps
- ☐ Osteoporosis
- ☐ Pacemaker
- ☐ Paralysis
- ☐ Pneumonia
- ☐ Rubella
- ☐ Seizures
- ☐ STDs: _____
- ☐ Tuberculosis
- ☐ Ulcers

Other _____

HOSPITALIZATIONS & SURGERIES

Include condition/reason	Date
1.	
2.	
3.	

ACCIDENTS

_____

_____

_____

FAMILY HISTORY

Check any of the following that have occurred in your immediate family, and list the relative:

- ☐ Alcoholism _____
- ☐ Allergies _____
- ☐ Bleeding tendency _____
- ☐ Cancer _____
- ☐ Diabetes _____
- ☐ Heart disease _____
- ☐ High cholesterol _____
- ☐ Hypertension _____
- ☐ Mental illness _____
- ☐ Nervous system disorder _____
- ☐ Obesity _____
- ☐ Other _____

AREAS OF PAIN OR DISCOMFORT

Please mark any areas of pain and any scars on the figures (indicate which areas are scars).

THE QUALITY OF THE PAIN IS

☐ Sharp ☐ Burning ☐ Aching

☐ Cramping ☐ Dull ☐ Moving ☐ Fixed

☐ Other: _____

WHAT ALLEVIATES THE PAIN?

☐ Pressure ☐ Cold ☐ Heat

☐ Movement/Exercise ☐ Rest

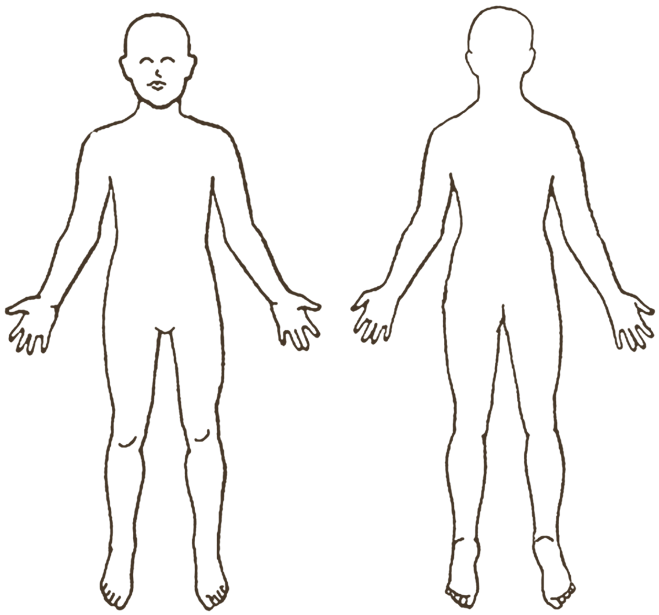
☐ Massage ☐ Other: _____

WHAT AGGRAVATES THE PAIN?

☐ Pressure ☐ Cold ☐ Heat

☐ Movement/Exercise ☐ Rest

☐ Massage ☐ Other: _____



FRONT BACK

PAIN LEVEL

Circle your pain level (1 is the least pain, 10 is the most).

(1) (2) (3) (4) (5) (6) (7) (8) (9) (10)

CHIEF COMPLAINT(S)

List in order of significance:	SEVERE	MODERATE	SLIGHT	NORMAL
1. _____	☐	☐	☐	☐
2. _____	☐	☐	☐	☐
3. _____	☐	☐	☐	☐
4. _____	☐	☐	☐	☐
5. _____	☐	☐	☐	☐

How do your conditions impair daily activities?

_____

_____

_____

_____

REVIEW OF SYSTEMS

Check any symptoms you experience.

HEART Cardiovascular

- ☐ Palpitations
- ☐ Anxiety
- ☐ Mouth ulcerations/sores
- ☐ Mental restlessness/confusion
- ☐ Chest pain traveling to shoulder
- ☐ Frequent dreams
- ☐ Wake unrefreshed
- ☐ Drink coffee (# cups/week: _____)

SPLEEN Gastrointestinal

- ☐ Low appetite
- ☐ Abrupt weight gain
- ☐ Abrupt weight loss
- ☐ Abdominal bloating
- ☐ Gas
- ☐ Borborygmus (gurgling sounds in abdomen)
- ☐ Fatigue
- ☐ Fatigue after eating
- ☐ Prolapsed organs: _____
- ☐ Easily bruised
- ☐ Hemorrhoids
- ☐ Over-thinking
- ☐ Worrisome
- ☐ Loose stool
- ☐ Incomplete sensation of bowel movement
- ☐ Fatigue after bowel movement
- ☐ Constipation
- ☐ Diarrhea
- ☐ Mucus in stool
- ☐ Undigested food in stool

STOMACH Gastrointestinal

- ☐ Heartburn
- ☐ Hearty appetite, even after eating
- ☐ Foul breath
- ☐ Mouth sores (canker sores)
- ☐ Bleeding, swollen, or painful gums
- ☐ Acid regurgitation
- ☐ Ulcer
- ☐ Stomach pain
- ☐ Vomiting

LARGE INTESTINE Gastrointestinal

- ☐ Bloody stool

LUNG Respiratory

- ☐ Cough
- ☐ Nasal discharge (color: _____)
- ☐ Sinus congestion
- ☐ Dry throat
- ☐ Dry skin
- ☐ Seasonal allergies
- ☐ Asthma
- ☐ Catches colds easily
- ☐ Wheezing
- ☐ Sneezing
- ☐ Headache (location: _____)
- ☐ Sore throat
- ☐ Sadness/Grief/Melancholy
- ☐ Stiff neck
- ☐ Stiff shoulders
- ☐ Smoker (# cigarettes/day: _____)

LIVER

- ☐ Sensation of lump in throat
- ☐ Easily angered
- ☐ Frustration
- ☐ Depression
- ☐ Irritability
- ☐ Dizziness
- ☐ Brittle nails
- ☐ Skin rashes (describe: _____)
- ☐ Headache at top of head
- ☐ Muscle spasms
- ☐ Muscle cramping
- ☐ Muscle twitching
- ☐ Neck tension
- ☐ Shoulder tension
- ☐ Frequent sighing
- ☐ Seizures/Convulsions
- ☐ Numbness (location: _____)
- ☐ Hypertension
- ☐ Migrating pain
- ☐ Alternating diarrhea and constipation
- ☐ High-pitched ear ringing
- ☐ Alcohol consumption (# drinks/week: _____)
- ☐ Gallstones (current or past history)
- ☐ STDs (type & date: _____)

REVIEW OF SYSTEMS (continued)

KIDNEY Urogenital

- ☐ Cold hands
- ☐ Cold feet
- ☐ Sweaty hands
- ☐ Sweaty feet
- ☐ Hot body sensation
- ☐ Cold body sensation
- ☐ Afternoon flushes
- ☐ Night sweats
- ☐ Heat sensation in hands and feet
- ☐ Thirst
- ☐ Thirst at night
- ☐ Perspire easily
- ☐ Low-pitched ear ringing
- ☐ Sore low back
- ☐ Sore/weak knees
- ☐ Frequent cavities
- ☐ Wakes frequently to urinate (2 times or more)
- ☐ Easily startled
- ☐ Fearful

BLADDER Urogenital

- ☐ Lack of bladder control
- ☐ Bladder infections

URINATION

- ☐ Normal color (pale yellow)
- ☐ Dark yellow
- ☐ Clear
- ☐ Reddish
- ☐ Cloudy
- ☐ Scanty
- ☐ Profuse
- ☐ Strong odor
- ☐ Burning
- ☐ Painful
- ☐ Urgent
- ☐ Difficulty emptying bladder

EYES

- ☐ Floaters in eyes (black spots)
- ☐ Itchy
- ☐ Bloodshot
- ☐ Dry
- ☐ Watery
- ☐ Gritty
- ☐ Blurry vision

DAMP

- ☐ Sensation of heaviness in body
- ☐ Mental heaviness
- ☐ Mental sluggishness
- ☐ Mental fogginess
- ☐ Swollen hands
- ☐ Swollen feet
- ☐ Swollen joints
- ☐ Chest congestion
- ☐ Nausea
- ☐ Snoring

LIBIDO

☐ Normal ☐ High ☐ Low

OTHER SYMPTOMS

_____

_____

_____

MEN ONLY

- ☐ Enlarged prostate
- ☐ Swollen testes
- ☐ Impotence
- ☐ Premature ejaculation
- ☐ Nocturnal emissions
- ☐ Coldness/numbness in external genitalia

OTHER COMMENTS

_____

_____

_____

WOMEN ONLY

MENSTRUATION

Age of first menstruation: _____

Regular menstrual cycle? ☐ Y ☐ N

If no, indicate irregularities:

_____

_____

Flow: ☐ Normal ☐ Scanty ☐ Heavy

Average # of days of flow: _____

Average # of pads/tampons per day: _____

# of days between cycles: _____

Color of blood:

☐ Dark red ☐ Fresh red ☐ Bright red

☐ Pale red ☐ Other: _____

Clots: ☐ Y ☐ N

Size: ☐ Quarter ☐ Nickel ☐ Dime ☐ Pea

Color: ☐ Dark purple ☐ Brown ☐ Bright red

Cramps: ☐ Y ☐ N

If yes, indicate location and severity:

_____

Bleeding between periods: ☐ Y ☐ N

If yes, indicate color, amount, and consistency:

_____

PREGNANCY

Currently pregnant? ☐ Y ☐ N

_____

_____

# of pregnancies: _____ # of live births: _____

# of abortions: _____

MENOPAUSE

Age of menopause (if applicable): _____

Menopause symptoms:

☐ Night sweats ☐ Hot flashes ☐ Loss of libido

☐ Vaginal dryness ☐ Sleep disorder ☐ Anxiety

☐ Mood swings ☐ Dizziness ☐ Weight gain

☐ Itchy skin

☐ Other: _____

VAGINAL DISCHARGE

☐ None ☐ Light ☐ Moderate ☐ Heavy

☐ Thick ☐ Thin

☐ Clear ☐ White ☐ Yellow

☐ Odorous

PMS SYMPTOMS

☐ Nausea
☐ Water retention
☐ Vomiting
☐ Breast tenderness
☐ Headaches
☐ Bloating
☐ Irritability
☐ Migraines
☐ Depression
☐ Anxiety
☐ Alternating diarrhea & constipation

☐ Food cravings: _____

☐ Body pain: _____

☐ Other emotions: _____

☐ Other: _____

_____ _____

PATIENT SIGNATURE DATE

_____ _____

ACUPUNCTURIST SIGNATURE DATE