

Your First Wealth Is Health



## Patient History and Health Questionnaire

Name \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_  
\_\_\_\_\_

Cell Phone \_\_\_\_\_ Home Phone \_\_\_\_\_ Office Phone \_\_\_\_\_

Date of Birth \_\_\_\_\_ Age \_\_\_\_ Weight \_\_\_\_ Height \_\_\_\_ Gender \_\_\_\_\_

Emergency Contact Name \_\_\_\_\_ Phone \_\_\_\_\_

Marital Status \_\_\_\_\_ Blood Type \_\_\_\_\_

Primary Health Care Provider \_\_\_\_\_

Insurance Type \_\_\_\_\_

Occupation \_\_\_\_\_ Employer \_\_\_\_\_

Email Address \_\_\_\_\_

Referred By \_\_\_\_\_

Have you ever received acupuncture before? Yes / No

*Traditional Chinese Medicine is a system that views the person as a whole. It may not be apparent to you how some of these questions are related to your health problem, but your answers will provide a framework for helping us to understand you as an individual and to effectively treat your condition.*

Reason for visit: \_\_\_\_\_

Medical History (include surgeries, childhood illnesses, extended antibiotic treatment, accidents, occupational stressors)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Family Medical History (include major events of first and second degree relatives)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Are you adopted? Yes / No



## Lifestyle

### Diet

How is your appetite? Increased / Decreased / No Change

Number of meals per day \_\_\_\_\_

What tastes/foods do you crave? (please circle all that apply)

Sweet Salty Sour Hot/spicy Bland Crunchy Other:

Daily Diet: \_\_\_ Std. American Diet (SAD) \_\_\_ Vegetarian \_\_\_ Whole Foods

Are you often thirsty? Yes / No If yes, for hot? \_\_\_ for cold? \_\_\_ room temp? \_\_\_

### Habits

Alcohol: Yes / No Number of drinks per day or week \_\_\_\_\_

Tobacco: Yes / No What and how much \_\_\_\_\_

Coffee: Yes / No Cups/day \_\_\_\_\_ How big is your cup? \_\_\_\_\_

Soda: Yes / No Amount/day \_\_\_\_\_

Sweet Treats: Yes / No Amount/day \_\_\_\_\_

### Stress

Do you feel that your life is stressful? Yes / No

Describe \_\_\_\_\_

### Sleep Habits (please check all that apply)

- Hard to fall asleep
- Insomnia with indigestion
- Restless dreaming
- Easy to wake, hard to fall back to sleep
- Wake up too early
- Wake tired in the morning

Average number of hours of sleep/night \_\_\_\_\_

### Exercise

Do you exercise regularly? Yes / No How often \_\_\_\_\_

Types of exercise \_\_\_\_\_

*"Exercise ferments the humors, casts them into their proper channels, throws off redundancies and helps nature in those secret distributions, without which the body cannot subsist in its vigor, nor the soul act with cheerfulness."*

– Joseph Addison, British Poet/Politician 1672-1719



Please indicate any past or present health complaints by checking the appropriate box and provide a brief explanation if appropriate

Present Past

**Head, Eyes, Ears, Nose, Throat, Mouth**

- Headaches
- Migraines
- Dizziness
- Eye pain
- Visual disturbances
- Spots/floaters in eyes
- Recurrent sore throat
- Dry throat
- Dry mouth
- Lump in throat
- Taste in mouth, describe \_\_\_\_\_
- Smelly breath
- Excess or deficient saliva/mucous
- Receding / bleeding gums
- Mercury / amalgam fillings
- Sores on lips, tongue or gums
- Sinus congestion / infections
- Poor hearing / hearing aids
- Earaches
- Ringing in ears (tinnitus)

**Cardiovascular**

- Heart palpitations (fluttering sensation)
- Cold hands/feet
- Chest pain/pressure
- Fainting
- High blood pressure
- Low blood pressure
- Elevated cholesterol
- Heart attack
- Heart surgery
- Stroke / TIA
- Varicose veins
- Enlarged heart
- Bruising/bleeding
- Anemia

Present Past

**Gastrointestinal**

- Nausea
- Vomiting
- Abdominal pain or cramps
- Belching
- Difficulty Swallowing
- Gas
- Heartburn (acid reflux)
- Ulcers
- Constipation/diarrhea
- Loose stools
- Irritable bowel/spastic colon
- Black stools
- Blood in stool
- Rectal pain
- Hemorrhoids
- Hepatitis
- Liver/gallbladder disorder
- Diabetes
- Anorexia
- Bulimia

**Respiratory**

- Cough
- Bloody sputum
- Pain on deep breathing
- Production of phlegm, color \_\_\_\_\_
- Asthma
- Shortness of breath
- Difficult inhalation/exhalation
- Emphysema
- Nasal discharge
- Post nasal drip
- Sleep apnea/snoring
- Allergies to \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Present Past

### Neuromuscular/skeletal

- Neck pain
- Spinal stiffness / tightness
- Upper back pain
- Lower back pain
- Shoulder pain
- Elbow/upper arm pain
- Elbow/upper arm numbness/tingling
- Wrist pain
- Hand pain
- Hip/upper leg pain
- Hip/upper leg numbness/tingling
- Knee/lower leg pain
- Knee/lower leg numbness/tingling
- Ankle/foot pain
- Jaw pain/clenching
- Joint swelling/stiffness
- Arthritis
- Rheumatoid arthritis
- Muscular incoordination
- Loss of balance
- Weakness
- Epilepsy
- Numbness/tingling, where \_\_\_\_\_
- Tremor

### Neuropsychological

- Mood swings
- Depression/Anxiety
- Drug/alcohol dependence
- Seizures
- Decreased memory
- Lack of concentration
- Seasonal Affective Disorder
- Startle Easily

### Dermatological

- Acne
- Itching, where \_\_\_\_\_
- Rash / purpura
- Eczema / Psoriasis
- Nail fungus / Athlete's foot
- Excessively dry skin
- Hair loss
- Dandruff

Present Past

### Genitourinary

- Pain/burning on urination
- Bladder infections
- Urgency to urinate
- Decrease in flow
- Waking at night to urinate
- Frequent urination
- Delay in starting stream
- Loss of bladder control
- Color of urine (clear, dark, cloudy)
- Blood in urine
- Discharge of mucous
- Kidney stones
- Kidney disorders
- Erectile dysfunction
- Prostate problems

### Miscellaneous

- General fatigue / poor energy
- Weight loss / gain
- Fever / chills
- Cancer / tumors
- Lymph node removal
- Thyroid issues
- Systemic Lupus
- HIV/AIDS
- Low sexual function
  - Born prematurely
  - # of siblings \_\_\_\_\_

### List scars, tattoos, piercings and mole removals:

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### For Women:

Any chance of being pregnant now? Yes / No  
 # of pregnancies \_\_\_\_ Miscarriages \_\_\_\_ Abortions \_\_\_\_

Menstruation: Regular \_\_ Irregular \_\_ Age at onset \_\_\_\_  
 Birth Control Pills Yes / No Infertility Yes / No  
 IUD Yes / No Other birth control \_\_\_\_\_

Period comes every \_\_\_\_ days and lasts \_\_\_\_ days  
 Cramps Yes / No Describe \_\_\_\_\_

PMS Yes / No Describe \_\_\_\_\_

Vaginal Discomfort/Discharge \_\_\_\_\_

Fibroids \_\_\_\_ Endometriosis \_\_\_\_ PCOS \_\_\_\_

### Menopause:

When \_\_\_\_\_ Hormone Replacement Therapy \_\_\_\_

Do you have associated discomfort at present? Yes / No  
 Hysterectomy Yes / No Date and Reason \_\_\_\_\_

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