Health History Questionnaire

Information for your Acupuncturist

Important: Complete this document as thoroughly as possible. Some of the questions that follow may seem unrelated to your condition but may play a major role in diagnosis and treatment.
All information is strictly confidential.

I. General Patient Information Date: ___ / ___ / _____

Name: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Home Phone: _____ Work Phone: _____
Email Address: _____
Age: _____ Date of Birth: ___ / ___ / _____ Place of Birth: _____
Guardian (if under 18 years old): _____
Gender: M / F Height: ___' ___" Weight: _____lbs Marital Status: _____
Occupation: _____ Employer: _____
How did you hear about our office? _____
Emergency Contact
Name, Phone number, and relation to patient:

Have you ever been treated by Acupuncture or Oriental Medicine before? Yes No
Main conditions you would like us to help you with, in order of significance:

1. 4.
2. 5.
3. 6.

How long ago did these problem(s) begin, please be specific:

To what extent do these problems affect your daily activities such as work, sleep, or hobbies?

What kinds of treatment have you tried and how have they worked?

Have you been given a diagnosis for any of these problems, if so, what?

II. Past Medical History

How was your childhood health?

List all hospitalizations, surgeries, auto accidents, trauma, falls:

Allergies (food, seasonal, environmental):

Recent Tests (Please indicate test results and date):

Physical	Cholesterol	Prostate	Blood (which)
HIV/STD	Pap Smear	Mammography	Other: _____

Test results and Date: _____

Circle any you have had in the past:

Allergies	Glaucoma	Rheumatic Fever	Heart Disease	CVA (Stroke)
Vein condition	Asthma	Pneumonia	Tuberculosis	Emphysema
Mumps	Jaundice	Gonorrhea	Syphilis	Bleeding Tendency
Measles	Meningitis	Chicken Pox	Epilepsy	Nervous Disorder
High Fever	Hepatitis	Mononucleosis	HIV/AIDS	Thyroid Disorder
Polio	Paralysis	Cancer	Migraines	High Blood Pressure
Lung Disorder	Liver Disorder	Kidney Disorder	Spleen Disorder	Stomach Disorder

Other: _____

Immunizations: _____

Family Medical History: Please circle all that apply in your immediate family

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

III. Patient Profile:

Please list all medications taken in the last 3 months (including drugs, vitamins, and herbs):

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

Do you have a regular exercise program? If yes, describe:

Are you on a restricted diet? If yes, describe:

How much water do you drink daily?

How many caffeinated drinks do you drink per week (coffee, teas, soda)?

Do you smoke? If yes, how many cigarettes per day?

Pain conditions:

Indicate any areas of pain in the body and the location of any scars on the body:

Is the pain sensation:

Sharp	Burning Aching	Cramping	Dull	Moving	Fixed

Other: _____

Do any of the following lessen the pain:

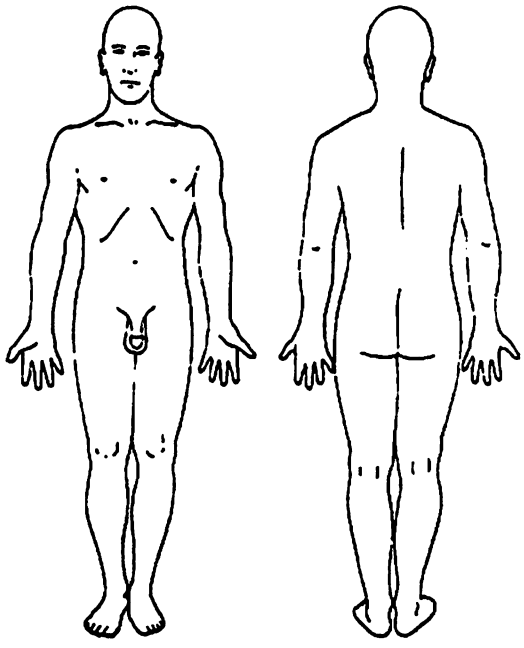
Pressure	Cold	Heat	Exercise	Other: _____

Do any of the following worsen the pain:

Pressure	Cold	Heat	Exercise	Other: _____

Circle any areas where you have pain, edema, swelling, or skin disorders:

Male



Female