ACUPUNCTURE
for Health

HEALTH QUESTIONNAIRE

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

All information is strictly confidential.

ACUPUNCTURE
for Health

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I. GENERAL PATIENT INFORMATION

DATE _____ NAME _____

ADDRESS _____ STE./APT. _____

CITY _____ STATE _____ ZIP CODE _____

PRIMARY PHONE _____ WORK PHONE _____

EMAIL _____ MAY WE CONTACT YOU ☐ at home ☐ at work ☐ email

AGE _____ DATE OF BIRTH _____ BIRTHPLACE _____

GENDER ☐ M ☐ F MARITAL STATUS ☐ Married ☐ Single HEIGHT ' " WEIGHT lbs.

OCCUPATION _____ EMPLOYER _____

HOURS WORKED PER WEEK _____ IS YOUR HEALTH COMPLAINT RELATED TO WORK? ☐ Yes ☐ No ☐ Maybe

HOW DID YOU HEAR ABOUT OUR OFFICE? _____

GUARDIAN *(if under 18)* _____ EMERGENCY CONTACT _____

RELATIONSHIP _____ PHONE _____

MAJOR COMPLAINT(S), in order of significance to you

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

HOW DO THESE CONDITIONS AFFECT YOUR LIFE? _____

II. PATIENT MEDICAL HISTORY

HOW WAS YOUR CHILDHOOD HEALTH?

HOSPITAL VISITS/STAYS

MARK RECENT TESTS AND CIRCLE ANY WITH ABNORMAL RESULTS

- ☐ Physical
- ☐ Cholesterol
- ☐ Prostate
- ☐ Blood
- ☐ HIV/STD
- ☐ Pap smear
- ☐ Mammogram
- ☐ Other

CHECK ANY YOU HAVE HAD IN THE PAST

- ☐ Diabetes
- ☐ Allergies
- ☐ Glaucoma
- ☐ Rheumatic Fever
- ☐ Heart disease
- ☐ CVA (stroke)
- ☐ Vein condition
- ☐ Thyroid disorder
- ☐ Asthma
- ☐ Pneumonia
- ☐ Tuberculosis
- ☐ Emphysema
- ☐ Jaundice
- ☐ Gonorrhea
- ☐ Mumps
- ☐ Bleeding tendency
- ☐ Syphilis
- ☐ Measles
- ☐ Chicken pox
- ☐ Nervous disorder
- ☐ Meningitis
- ☐ HIV
- ☐ Polio
- ☐ Mononucleosis
- ☐ Epilepsy
- ☐ High fever
- ☐ Hepatitis
- ☐ Multiple sclerosis
- ☐ Paralysis
- ☐ Cancer
- ☐ Migraines
- ☐ High blood pressure
- ☐ Other lung illnesses
- ☐ Other liver illnesses
- ☐ Other heart illnesses
- ☐ Other kidney illnesses
- ☐ Vasectomy
- ☐ Sleep apnea
- ☐ Shingles
- ☐ Anemia
- ☐ Other

IMMUNIZATIONS

SURGERIES

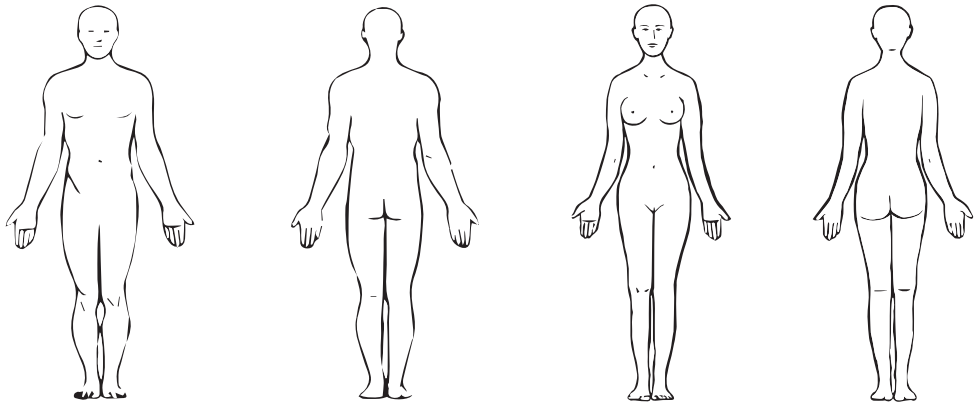
SERIOUS INJURIES OR ACCIDENTS

FAMILY HISTORY

- ☐ Cancer
- ☐ Diabetes
- ☐ High blood pressure
- ☐ Stroke

III. PATIENT PROFILE

Please clearly mark any areas of pain with **X**, scars with **–** and numbness with **O**



DESCRIBE THE PAIN

- ☐ Sharp
- ☐ Dull
- ☐ Burning
- ☐ Moving
- ☐ Aching
- ☐ Fixed
- ☐ Cramping
- ☐ Other _____

DO THE FOLLOWING LESSEN THE PAIN?

- ☐ Pressure
- ☐ Cold
- ☐ Heat
- ☐ Exercise
- ☐ Other _____

DO THE FOLLOWING WORSEN THE PAIN?

- ☐ Pressure
- ☐ Cold
- ☐ Heat
- ☐ Exercise
- ☐ Other _____

OVERALL ENERGY

- ☐ Low energy
- ☐ General weakness
- ☐ Easily catch colds
- ☐ Difficulty keeping eyes open in the daytime
- ☐ Feel worse after exercise
- ☐ Overall achy feeling in the body
- ☐ Low libido
- ☐ High libido
- ☐ General sensation of heaviness in the body
- ☐ Mental heaviness
- ☐ Mental fogginess
- ☐ Dizziness
- ☐ Swollen joints *where?* _____
- ☐ Edema *where?* _____
- ☐ Skin is often damp or moist

OVERALL TEMPERATURE // KIDNEY FUNCTION

- ☐ Cold body temperature (>sensitive than avg. person)
- ☐ Chilled to the bone (hard to get warm again)
- ☐ Afternoon flushes
- ☐ Night sweats
- ☐ Heat in the hands, feet, and chest
- ☐ Hot flashes
- ☐ Cold sensation in the knees
- ☐ Hot body temperature
- ☐ Alternating fevers and chills
- ☐ Take water to bed
- ☐ Excessive thirst
- ☐ Rarely perspire...
- ☐ Even when exercising
- ☐ Graying hair

HEART & CIRCULATION FUNCTION

- ☐ Mental confusion
- ☐ Chest pain
- ☐ Chest pain traveling to shoulder
- ☐ Drink coffee *# cups/week* _____
- ☐ Difficulty falling asleep
- ☐ Difficulty staying asleep
- ☐ Nightmares
- ☐ Wake unrefreshed
- ☐ Anxiety
- ☐ Restlessness
- ☐ Palpitations
- ☐ Chest tightness
- ☐ Sores on tip of tongue
- ☐ Pain radiating down arm
- ☐ Vericose veins *where?* _____
- ☐ Spider veins *where?* _____

RESPIRATORY SYSTEM // LUNG FUNCTION

- ☐ Difficulty breathing
- ☐ Shortness of breath
- ☐ Cough
- ☐ Chest congestion
- ☐ Asthma ☐ ongoing ☐ in the past
- ☐ Smoke cigarettes *# cigarettes/day* _____
- ☐ Chew tobacco
- ☐ Sleep apnea
- ☐ Sadness ☐ Melancholy
- ☐ Dry skin ☐ Cracks in hands or feet

DIGESTIVE POWER // STOMACH FUNCTION

- ☐ Low appetite ☐ Excessive appetite ☐ Abrupt weight gain ☐ Abrupt weight loss
- ☐ Fatigue after eating ☐ Easily bruised ☐ Hemorrhoids ☐ Over-thinking
- ☐ Heart burn ☐ Acid reflux ☐ Nose bleeds ☐ Worry
- ☐ Mouth sores ☐ Bad breath ☐ Stomach pain ☐ Nausea
- ☐ Vomiting ☐ Abdominal bloating ☐ Belching ☐ Hiccoughs
- ☐ Gurgling noise ☐ Ulcer (diagnosed) ☐ Feel better after eating ☐ Feel worse after eating
- ☐ Burning sensation after eating
- ☐ Other bleeding issues *describe* _____
- ☐ Prolapsed organs *which organs?* _____

LARGE & SMALL INTESTINE FUNCTION

- ☐ Loose stools ☐ Constipation ☐ Blood in stools
- ☐ Diarrhea ☐ Incomplete BM (bowel movement) ☐ Mucous in stools
- ☐ Alternating diarrhea & constipation ☐ Undigested food in stools ☐ Frequent BM *#/day* _____

LIVER & GALLBLADDER FUNCTION

- ☐ Gallstones ☐ in past ☐ current
- ☐ Anger easily
- ☐ Depression
- ☐ Seizures
- ☐ Pain in the ribs
- ☐ Tightness in the chest
- ☐ Bitter taste in mouth
- ☐ Tingling sensation
- ☐ PMS symptoms
- ☐ Restless legs syndrome
- Muscle ☐ twitching ☐ spasms ☐ cramping
- ☐ Recreational drugs *which?*

- ☐ Gallbladder removed
- ☐ Frustration
- ☐ Irritability
- ☐ Convulsions
- ☐ Skin rashes *where?*
- ☐ Drink alcohol
- ☐ Headache at the side(s) of the head
- ☐ Numbness
- ☐ Weak fingernails
- ☐ Exposure to toxins
- ☐ Cold hands ☐ Cold feet

KIDNEY & URINARY BLADDER FUNCTION

- ☐ Frequent cavities & other dental problems
- ☐ Easily break bones
- ☐ Weakness in lower back
- ☐ Memory problems
- ☐ Excessive hair loss

- ☐ Kidney stones
- ☐ Wake during night 2+ times to urinate
- ☐ Lack of bladder control
- ☐ Fear
- ☐ Easily startled

URINATION

- ☐ Dark yellow (often) ☐ Burning ☐ Reddish ☐ Blood in urine
- ☐ Painful ☐ Cloudy ☐ Difficult ☐ Urgent
- ☐ Scanty ☐ Frequent ☐ Profuse ☐ Strong odor
- ☐ Interrupted ☐ Discharge ☐ Weak stream ☐ Bladder infections
- ☐ Sexually transmitted disease *which?*

MUSCLE & SKELETAL

- ☐ Neck tension ☐ Neck pain ☐ Painful knees ☐ Weak knees
- ☐ Low back pain ☐ Shoulder tension ☐ Shoulder pain ☐ Hip pain
- ☐ Pain radiating down leg ☐ Upper back tension ☐ Upper back pain ☐ Pain in hands
- ☐ Pain in feet ☐ Limited range of motion in neck ☐ Limited range of motion in shoulder
- ☐ Muscle weakness *where?*
- ☐ Loss of muscle function or paralysis *where?*

WOMEN ONLY

- ☐ Irregular menstrual cycle *for how long?* ☐ Regular menstrual cycle
- Pregnant ☐ yes ☐ no # of children # of pregnancies
- Age of 1st menstruation Age of 1st menopause *(if applicable)*
- Average # days of flow Average # days of entire cycle
- ☐ Severe menstrual cramps ☐ Bleeding between periods ☐ Mild menstrual cramps
- ☐ Unusual vaginal discharges *describe*

Do you experience any of the following pre-menstrual syndromes (PMS)?

☐ Nausea ☐ Vomiting ☐ Water retention ☐ Breast swelling
☐ Food cravings ☐ Headaches ☐ Migraines ☐ Breast tenderness
☐ Depression ☐ Anxiety ☐ Other emotions _____
☐ Dull pain *where?* _____ ☐ Sharp pain *where?* _____

How many days before period does PMS start? _____

Women, please fill out menstrual chart:

	Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7
Color *(bright red, pale, brown, rusty, dark, purple, other)*							
Flow *(heavy or light)*							
Pain/cramps *(location, dull, sharp, other)*							
Vomiting *(check if yes)*							
Nausea *(check if yes)*							
Other							

MEN ONLY

☐ Swollen testes ☐ Testicular pain ☐ Impotence ☐ Premature ejaculation
☐ Erectile dysfunction ☐ Vasectomy ☐ Unusual discharges
☐ Coldness or numbness in external genitalia ☐ Other _____

LIFESTYLE CHOICES

☐ Drink caffeinated beverages *# cups per day* _____ ☐ Drink or use artificial sweeteners

Exercise ☐ mild ☐ moderate ☐ vigorous # of hours of exercise per week _____

Diet ☐ vegan ☐ vegetarian

Foods that are avoided _____

MEDICATIONS

☐ Antacids ☐ Antibiotics ☐ Aspirin ☐ Birth control pills
☐ Blood thinning pills ☐ Cortisone ☐ Cough medicine ☐ Digitalis
☐ Hormones ☐ Insulin, diabetic pills ☐ Iron ☐ Laxatives
☐ Pain medication ☐ Sleeping pills ☐ Blood pressure medication ☐ Tranquilizers
☐ Vitamins ☐ Water pills ☐ Weight loss pills ☐ Thyroid medication
☐ Other *please list all other prescriptions, over-the-counter medications and supplements you use* _____

OTHER COMMENTS _____

PATIENT SIGNATURE _____