HEALTH HISTORY QUESTIONNAIRE

Please help us provide you with a complete evaluation by taking the time to fill out this questionnaire carefully. All your answers will be kept absolutely confidential. If you have questions, please ask. If there is anything you wish to bring to our attention which is not asked on this form, please note it in the Comments section. Thank you.

Name: _____

Street: _____ City: _____ State: _____ Zip: _____

Age: _____ Height: _____ Weight: _____

Home Phone: _____ Work: _____Cell: _____

Date + Place of Birth: _____ Social Security #: _____

Occupation: _____ Marital Status: _____

Emergency Contact + Phone: _____

Primary Care Physician: _____ OBGYN: _____

Other Specialist or Healthcare Provider(s): _____

Have you tried acupuncture or Chinese herbal medicine before? _____

MAIN PROBLEM(S) YOU WOULD LIKE TO ADDRESS: _____

_____

To what extent does this problem affect your daily activities (work, sleep, eating, etc)? _____

_____

How long has it been since you first noticed any symptoms? _____

Have you been given a diagnosis for the problem by a physician? _____

If so, what is the diagnosis? _____

What kinds of treatment have you tried? _____

PAST MEDICAL HISTORY (Please include dates):

- ☐ Allergies _____
- ☐ Diabetes _____
- ☐ High Blood Pressure _____
- ☐ Seizures _____
- ☐ Surgeries _____
- ☐ Thyroid Disorder _____
- ☐ Cancer _____
- ☐ Hepatitis _____
- ☐ Heart Disease _____
- ☐ Rheumatic Fever _____
- ☐ Venereal Disease _____
- ☐ Other significant illness (describe) _____
- ☐ Accidents or Significant Trauma (describe) _____

Birth History (prolonged labor, forceps delivery, C-section, etc) _____

_____

OTHER RELEVANT MEDICAL HISTORY: _____

_____

_____

FAMILY MEDICAL HISTORY (please list whom):

- ☐ Allergies _____
- ☐ Cancer _____
- ☐ Seizures _____
- ☐ Diabetes _____
- ☐ Heart Disease _____
- ☐ Stroke _____
- ☐ Asthma _____
- ☐ High Blood Pressure
- ☐ Other _____
- _____

OCCUPATION: _____

Occupational stress factors (physical, psychological, chemical): _____

_____

LIFESTYLE:

Do you follow a regular exercise program? _____ If so, please describe _____

_____

Please describe your average daily diet: _____

_____

Please check any of the following habits that apply. Indicate how much and how often you consume them:

☐ Cigarette smoking _____ ☐ Coffee, Tea, or Cola _____ ☐ Alcoholic beverages _____

_____

Medications taken within the last two months (including vitamins, drugs, herbs, etc) _____

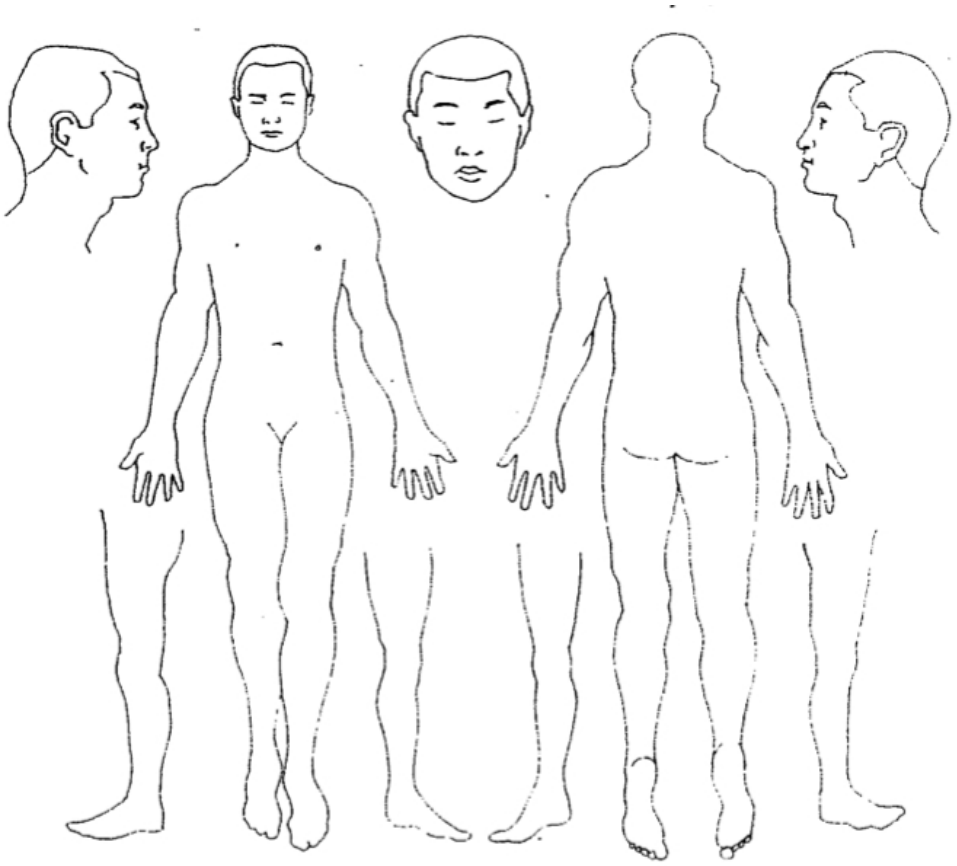
_____

Please describe any use of drugs for non-medical purposes: _____

_____

INDICATE PAINFUL OR DISTRESSED AREAS (or circle appropriate adjectives):

Symbol	Reaction
Pain on pressure	
X XX XXX	little moderate strong
Swelling	
∧ ∧ ∧ ∧ ∧ ∧	slight moderate severe
Tension/Weakness	
≈ #	weak tense
Spontaneous Pain	
† †† †††	slight moderate severe
Pulsing	
o oo ooo	slight moderate severe
Temperature	
– +	colder hotter
Physical	
⊗ ▽ ⇒⇐	sores rashes spasms



The following is a list of symptoms which you may or may not experience. Please indicate as follows:

_____ = never experience __o__ = occasionally experience __+__ = frequently experience

SECTION 1: QI

A. *Deficiency*

___ catch cold easily
___ fatigue easily
___ shortness of breath
___ sweat easily
___ dizziness
___ hard to project voice
___ dull headache

B. Stagnation

___ intermittent dull pain
___ bloating &/or fullness
___ sighing
___ sensation of object caught in throat
___ moodiness prior to menses

C. Rebellious

___ cough &/or asthma
___ vomiting
___ belching, hiccups

D. Prolapse

___ organ prolapse
___ dizziness
___ constant fatigue
___ shortness of breath
___ chronic diarrhea
___ descending sensation

SECTION 2: XUE

A. Deficiency

___ dizziness
___ pale face & nails
___ blurred vision
___ palpitations
___ numbness
___ women: scanty menses

B. Stagnation

___ localized sharp pain
___ lumps, mass or tumor
___ large red spots under skin
___ women: painful menses
___ irregular periods

C. Heat

___ feverish
___ irritable
___ bleeding
___ red, painful skin eruptions
___ women: heavy menses

SECTION 3: YANG

A. Excess Heat

___ feverish
___ sweat easily
___ thirsty
___ constipation
___ red face
___ sore throat, mouth
___ dark, scanty urine
___ irritable

B. Deficient

___ cold body & limbs
___ low sex drive
___ always tired
___ sleep a lot
___ water retention
___ edema

SECTION 4: YIN

A. Excess Cold

___ always cold
___ frequent clear urine
___ diarrhea
___ abdominal pain worse with pressure
___ symptoms relieved by heat or hot drinks
___ clear discharge

B. Deficient

___ feverish at night
___ night sweats
___ dry mouth/throat
___ feverish palms and soles of feet
___ irritable
___ insomnia
___ flushed cheeks

SECTION 5: JING

___ premature gray
___ hair loss
___ tooth loss
___ impotence
___ no sex drive
___ memory loss
___ infertility

SECTION 6: BF

___ hoarse voice
___ dry mouth/skin
___ dull, dry hair
___ thirsty
___ dry stools
___ scanty urine
___ dry eyes, nose

SECTION 7: WIND

A. External

___ sneezing
___ clear runny nose
___ dislike of wind
___ body & head achy
___ nasal congestion
___ chills & fever
___ neck & shoulders achy

B. Internal

___ spasms & tremors
___ dizziness or vertigo
___ stroke
___ stiffness
___ numbness
___ convulsions
___ seizures
___ paralysis

SECTION 8: DAMP

___ heaviness
___ bloat & swelling
___ edema
___ nausea
___ lack of thirst
___ milky discharge
___ loose stools
___ weight gain

SECTION 9: PHLEGM

___ chest fullness
___ cough up mucous
___ have to clear throat often
___ decreased appetite
___ wheezing
___ dizziness
___ mucous in stool

SECTION 10: LUNGS

___ allergies, hay fever
___ cough/asthma
___ shortness of breath
___ chest fullness/pain
___ awaken 3-5 am
___ grief & sadness
___ crying a lot
___ skin problems
___ bronchitis
___ sinusitis
___ decreased sense of smell

SECTION 11: L.I.

___ constipation
___ burning sensation in anus
___ hemorrhoids
___ colitis
___ diverticulitis
___ recent antibiotic use
___ blood in stool

SECTION 12: HEART

___ palpitations
___ anxiety
___ insomnia
___ excess dreams
___ chest pain
___ arm pain
___ sores or ulcers on tongue
___ hysteria
___ forgetfulness
___ nightmares
___ laughing for no apparent reason

SECTION 13: S.I.

___ bearing down sensation in groin or scrotum
___ abdominal pain
___ burning urination

SECTION 14: LIVER

___ rib or flank pain
___ depression
___ frustration
___ excess anger
___ migraine headache
___ vertigo
___ ear ringing
___ eyes red, painful
___ poor vision
___ poor nail growth
___ soft or brittle nails
___ headache on top of head
___ jaundice
___ hepatitis
___ spasms or muscle twitch
___ high cholesterol
___ high blood pressure

SECTION 15: G.B.

___ right trunk pain
___ gall stones
___ yellowing of skin
___ bitter taste in mouth
___ alternate chills & fever
___ nausea
___ vomit bitter fluids
___ acid regurgitation
___ frightens easily
___ indecisive
___ insomnia
___ headache on side of head
___ difficulty digesting oily foods
___ light colored stool

SECTION 16: SPLEEN

___ appetite low/none
___ diarrhea
___ abdominal bloat
___ nausea
___ bleeding
___ organ prolapse
___ worry too much
___ obsessive in work relationships
___ easily bruised
___ sudden weight loss

SECTION 17: ST

___ stomach ulcer
___ stomach pain
___ acid regurgitation
___ nausea/vomiting
___ swollen, painful gums
___ bad breath
___ always hungry
___ headache on forehead & behind eyes
___ heartburn
___ indigestion
___ gas
___ feeling of retained food
___ black "tarry" stool

SECTION 18: KIDNEY

___ pain & weak low back
___ knee problems
___ deafness
___ ear ringing
___ sciatica
___ incontinence of urine
___ nocturnal emission
___ sexual problems
___ hair loss
___ brittle bones
___ osteoporosis
___ infertility
___ poor memory
___ constant fear
___ frequent clear urine
___ scanty dark urine
___ difficult urination

SECTION 19: U.B.

___ painful burning urine
___ bladder/kidney stones
___ bloody/cloudy urine
___ headache back of head

SECTION 20: L.S.

___ overuse of alcohol
___ smoke marijuana
___ use cocaine
___ smoke tobacco
___ poor diet
___ overeat
___ use pharmaceuticals (list): _____
_____
_____
_____
_____

SECTION 21: MEN

___ prostate problems
___ hernia
___ pain or cold in genital area

SECTION 22: WOMEN

___ pregnant?
___ pre-menstrual pain or discomfort
___ irregular cycle
___ long cycle (+28 days)
___ short cycle
___ clotting
___ light flow
___ heavy flow
___ light color
___ dark color
___ swelling/painful breasts

COMMENTS: If you currently have or previously had any health problems or surgeries which are not listed above, or if you with so expand upon any of the above symptoms, please use the space below: