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HEALTH HISTORY QUESTIONNAIRE

Please help us provide you with a complete evaluation by taking the time to fill out this questionnaire carefully. All of your answers will be held 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_____ Date_____

Street_____ City_____

State/Zip _____ Home Phone_____

Cell Phone _____ eMail_____

Age_____ Date of Birth_____ Male Female Other _____

Height____ Weight _____

Marital Status: Married Never Married Widowed Divorced or Separated

Education: Grammar School High School College Masters Doctorate

Occupation:_____Retired:_____Disabled:_____Unemployed:_____

Family Physician: Referred by:

Emergency Contact:_____Emergency Contact Relation to you:_____

Emergency Contact telephone:

_____

Have you ever been treated by acupuncture or Oriental medicine before? Yes No

Main Problem you would like us to help you with:_____

_____

_____

_____

_____

_____

How long ago did this problem begin? Please be specific:

Have you been given a diagnosis for this problem? If so, what diagnosis and by whom?

How are your health problems interfering with the following areas of your life?

Work

_____

Family

_____

Hobbies

_____

Life

_____

Have you been treated for this problem? If so, what was the treatment and by whom?

_____

Was the treatment helpful? If yes, please explain how and to what degree it helped.

_____

Medicines taken within the last two months (vitamins, medications, herbs, drugs, etc.):

Past Personal Medical History of Significant Illness :
Asthma Allergies Diabetes Cancer Stroke Heart Disease High Blood Pressure

Seizures Hepatitis Rheumatic Fever Thyroid Disease Venereal Disease

Other: _____

Hospitalizations/Surgeries (including dates):
_____

Significant Trauma (auto accidents, falls, etc..):

Family Medical History:
Asthma Allergies Diabetes Cancer Stroke Heart Disease High Blood Pressure

Seizures Hepatitis Rheumatic Fever Thyroid Disease Venereal Disease

Other: _____

Do you follow any type of special diet (e.g. vegetarian, vegan, medical related, or other)? No Yes
If Yes, what type of diet?
_____
Describe your average daily diet:
Morning:_____

Afternoon: _____

Evening:_____

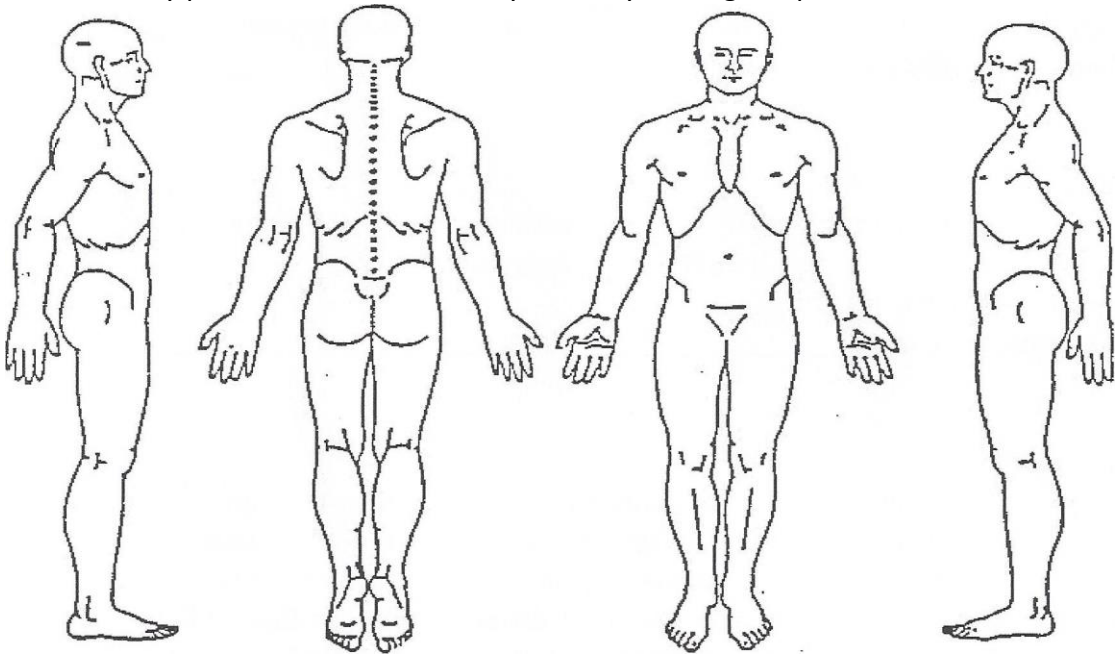
Do you: Smoke Vape If Yes, how many times per day? _____
How many cups of caffeinated coffee, tea, or cola do you drink per week?_____
How many 8 oz. glasses of water do you drink per day?_____
How many alcoholic beverages do you drink per week?_____

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

_____

_____

Please indicate any painful or distressed body areas by circling the particular area:



Are you pregnant: Yes No

Do you have a regular exercise program? Yes No If yes, please describe:

Please check all symptoms that you experience ACUTELY and CHRONICALLY

LUNG System Function *(Large Intestine, Thyroid, Thymus)*	**SPLEEN System Function** *(Stomach, Pancreas)*
○ Shortness of Breath ○ Wheezing/ Difficulty breathing/ Heaviness in chest/ Asthma ○ Nasal/Sinus Problems ○ Nose Bleeds ○ Cough (dry/ productive/ blood/ persistent) ○ Snoring ○ Loss of Smell/ Taste ○ Dry Nose/ Mouth ○ Dry / Sore Throat ○ Dry Skin ○ Allergies, Sneezing ○ Alternating fever/chills ○ Excessive Sweating ○ Difficult Sweating ○ Headaches ○ Stiff Neck & Shoulders ○ Chronic sadness ○ Constipation/ Difficult defecation ○ Hemorrhoids/ Blood/ Mucus in stools	○ Low appetite ○ Fatigue after eating ○ Loose stools/ Diarrhea ○ Undigested food in stool ○ Abrupt weight gain ○ Abrupt weight loss ○ Abdominal bloating/ Gas ○ Gurgling noise in stomach ○ Bleeding, swollen/ painful gums ○ Heartburn/ Acid regurgitation ○ Nausea/ Vomiting ○ Frequent belching/ hiccups ○ Frequent/ Constant hunger ○ Stomach pain ○ Bad breath ○ Canker sores in the mouth ○ Bruise easily ○ Always worrying/ over-thinking everything ○ Weak/ Atrophy in muscles ○ Whole body feels heavy ○ Fluid retention (edema, heavy limbs & body) ○ Swollen Feet/ Legs/ Joints

HEART System Function

(Pituitary gland, Small intestine)

- Anxiety/ Restlessness
- Sores on tip of tongue
- Speech problems
- Waking tired, unrefreshed
- Frequent dreams
- Mental sluggishness/fogginess
- Inability to focus (ADD, ADHD)
- Chest pain traveling to shoulder
- Fast heart beat (>100 beats/min)
- Slow heart beat (< 50 beats/min)
- Irregular heart beat
- Palpitations/ Heart fluttering

LIVER System Function

(Gall Bladder, Pineal gland)

- Alternating Diarrhea & Constipation
- Tight sensation in the chest
- Bitter taste in the mouth
- Irritable, angry & frustrated frequently
- Mood swings
- Suffer from depression
- Skin rashes (redness/itching)
- Headache at the top &s sides of the head/ Migraines
- Numbness/ Tingling sensation
- Muscle twitching/ Cramping/ Spasms
- Seizures/ Convulsions/ Tremors/ Tics
- Lump in the throat
- Neck & shoulder Tension/Tightness/Pain
- Joint Pain
- TMJ pain
- High-pitched ringing in ears
- Difficulty adapting to stress
- Teeth grinding
- Dizziness/ poor balance/ vertigo

EYES/VISION

- Itchy eyes
- Blood shot eyes
- Burning eyes
- Dry eyes
- Watery eyes
- Gritty eyes
- Blurry vision
- Decreased night vision
- Floaters in the eyes

KIDNEY System Function

(Urinary Bladder, Adrenal glands, Reproductive organs)

- Cold hands & feet
- Feels cold all the time in whole body
- Hot flashes & night sweats
- Thirsty all the time
- Frequent cavities, teeth problems
- Sore, achy/ weak knees
- Lower back pain
- Memory problems (short term, long term)
- Excessive hair loss, premature greying of hair
- Low-pitched ringing in the ears
- Poor hearing/ hearing problems
- History of chronic fear
- Easily startled
- General weakness, low energy, fatigue
- Excessive libido

URINATION

- Lack of bladder control (incontinence)
- Wake during the night > 1 to urinate
- Scanty urination
- Profuse urination
- Urgency to urinate
- Difficult/ Incomplete urination
- Painful/Burning urination
- Cloudy urine
- Reddish urine

WOMEN ONLY

- Amenorrhea (lack of menstruation)
- Irregular menstruation
- Scanty menstrual bleeding
- Profuse menstrual bleeding
- Painful menstruation
- Short cycle
- Long cycle
- Miscarriage (how many): _____

	KIDNEY System Function (continued) **WOMEN ONLY** (continued) ○ Infertility ○ Pregnancies: Live births ___ ○ Onset of menses (age): _____ ○ Menopause issues (Night sweats, hot flashes, anxiety, sleep issues etc.) **MEN ONLY** ○ Swollen testes ○ Testicular pain ○ Inability to maintain erection ○ Premature ejaculation

COMMENTS

Please tell us briefly of any other problems you would like to discuss:

_____