gold : acupuncture

## Health History Questionnaire

Name: _____Date _____
Address: _____
Home Phone _____ Cell Phone _____
Work Phone _____Email: _____
Social Security Number _____-_____-_____ Sex: ☐Female ☐Male
Height: _____Weight: _____ Date of Birth: _____ Age: _____
Occupation: _____Employer _____
Emergency Contact's Name and Number: _____
Who can I thank for your referral? Name _____
Add to our newsletter? (We only send important news and specials 3 times a year) ☐Yes ☐No
Are you under the care of a physician now? ☐Yes ☐No
If yes, for what ?_____
Physician's Name and Number _____

Does your health insurance cover acupuncture? If yes, please fill in next section, if not skip it.
Insurance name: _____ Group ID: _____
Subscriber ID _____Insurance Phone _____

Major Complaint/Health Problem:

_____

_____

How did this condition develop?

_____

_____

Is there anything that makes it worse?

_____

Is there anything that makes it better?

_____

Have you ever received treatment for this condition? _____ If yes, when? _____
By Whom? _____ Type of treatment? _____

What was the diagnosis?

_____

What were the results of treatment?

_____

To what extent does the problem interfere with your daily activity (work, exercise, sleep, sex,?)

_____

_____

**Personal Medical History** – please note dates:

☐ Allergies _____ ☐ Heart disease_____ ☐ Seizures _____

☐ Asthma _____ ☐ Hepatitis_____ ☐ Stroke _____

☐ Cancer _____ ☐ High blood pressure_____ ☐ STDs _____

☐ Diabetes _____ ☐ HIV/AIDS _____ ☐ Thyroid disease _____

**Family Medical History** – please note relationship:

☐ Allergies _____ ☐ Heart disease_____ ☐ Seizures _____

☐ Asthma _____ ☐ Hepatitis_____ ☐ Stroke _____

☐ Cancer _____ ☐ High blood pressure_____ ☐ Mental _____

☐ Diabetes _____ ☐ Drug/alcohol abuse _____ ☐ Thyroid disease _____

**Medications**

What medications are you taking? Please include prescription name, reason, and dosage.

_____

_____

What vitamin supplements are you taking? How much?

_____

_____

Surgeries (types & dates):

_____

_____

Significant Traumas:

_____

_____

Allergies (drugs, chemicals, foods, etc.)

_____

Occupational Stress (chemical, physical, psychological)

_____

**Habits**
Do you have a regular exercise program?

Type: _____Frequency: _____

Are you or have you been on a restricted diet? What kind and why?

_____

Please indicate usage per day or per week:

Cigarettes _____ per _____
Alcohol _____ per _____
Drugs _____ per _____
Coffee _____ per _____
Tea _____ per _____
Soft Drinks _____ per _____
Sugar _____ per _____
Other _____per _____

Please describe your average daily diet:
Morning: _____

Afternoon: _____

Evening: _____

## Do you suffer from any of the following?

Check all that apply, and for each note if it is current or past.

### General

☐Recurrent Infections
☐Night Sweats
☐Sweat easily
☐Bleed or bruise easily
☐Strong thirst (prefer hot or cold?)
☐Thirst with no desire to drink
☐Fatigue
☐Sudden energy drops
Time of day_____
☐Poor Sleep
☐Tremors
☐Poor Balance
☐Edema
☐Dizziness
☐Recurrent sore throat
☐Underweight
☐ Overweight

**Skin**
☐Rashes
☐Itching
☐Psoriasis
☐Pimples
☐Dry skin / scalp
☐Recent moles
☐Changes in hair/skin
☐Eczema
☐Other _____

**Head/Eyes/Ears/Nose/Throat**
☐Headaches
Where _____
When _____
☐Migraines

☐Discharge from ear
☐Poor hearing
☐Ringing in ears
☐ vision
☐Night blindness
☐Color blindness
☐Eye Pain
☐Excessive Tearing
☐Squint
☐Glasses: Age?
☐Sore eyes
☐Facial Pain
☐Nose bleeds
☐Nasal discharge
☐Blocked nose
☐Snoring
☐Grinding teeth
☐Teeth problems

☐Hoarseness
☐Tonsillitis
☐Swollen glands
☐Sores on lips/mouth
☐Spots in front of eyes
☐Other _____

**Cardiovascular**
☐Pacemaker
☐High Blood Pressure
☐Low Blood Pressure
☐Chest discomfort/pain
☐Heart Palpitations
☐Cold hands or feet
☐Swelling of hands or feet
☐Blood Clots
☐Spider veins
☐Fainting
☐Other _____
☐Changes in sex drive

**Respiratory**
☐Difficulty breathing
☐Pain with breathing
☐Shallow breathing
☐Shortness of breath
☐Production of phlegm
color _____
☐Recurrent cough
☐Bronchitis
☐Pneumonia
☐Asthma/Wheezing
☐Status asthmaticus
☐Other _____

**Digestion**
☐Bad breath
☐Change in appetite
☐Nausea
☐Vomiting
☐Heartburn
☐Indigestion
☐Belching
☐Abdominal pain or cramps
☐Weight gain
☐Weight loss
☐Loose stools / Diarrhea
☐Strong smelling stools
☐Bloody stools
☐Pale stools
☐Green stools
☐Black stools
(not daily, or difficult)
☐Pain with passing stools
☐Gas
☐Rectal pain
☐Hemorrhoids
☐Bulimia
☐Anorexia

**Genitourinary**
☐Pain on urination
☐Urgency with urination
☐Frequent urination
☐Blood in urine
☐Decrease in urinary flow
☐Unable to hold urine
☐Incontinence at night
☐Dribbling urination
☐Kidney stones
☐Prostate problems
☐Impotency
☐Hernia
☐Rashes
☐Do you wake at night to urinate?
How many times? _____
☐Other _____

**Gynecological**
# of pregnancies_____
# births_____
# miscarriages_____
# abortions_____
Age of 1st menses_____
# days between menses_____
Duration of menses_____
1st day of last menses_____
Age of menopause_____
Date of last PAP_____
Are you pregnant now?_____
☐PMS
☐Irregular periods
☐Painful periods
☐Light periods
☐Heavy periods
☐Clots
☐Fibroids
☐Endometriosis
☐Infertility
☐Vaginal discharge
☐Vaginal sores
☐Postcoital bleeding
☐Breast lumps
☐Nipple discharge

**Musculoskeletal**
☐Neck ache/pain
☐Back ache/pain
☐Knee ache/pain
☐Shoulder pain
☐Elbow/Forearm pain
☐Hand/Wrist pain
☐Foot/Ankle pain
☐Joint/Bone problems
☐Torn tissues
☐Prostheses
☐Muscle pain

☐Other_____

**Neurological**
☐Seizures
☐Nerve damage
☐Paralysis
☐Stroke
☐Sleep disorder
☐Concussion
☐Vertigo
☐Lack of coordination
☐Loss of balance
☐Poor memory
☐Difficult concentrating
☐Other _____

**Behavioral**
☐Vacant
☐Moody
☐Susceptible to stress
☐Aggressive/Bad temper
☐Overly emotional
☐Anxiety
☐Panic Attack
☐Depression
☐Fear
☐Substance abuse
☐Other _____

Have you ever
been treated for
emotional problems? __

Have you ever
attempted suicide?
_____

**Please note the severity of your problem right now:**

0 1 2 3 4 5 6 7 8 9 10

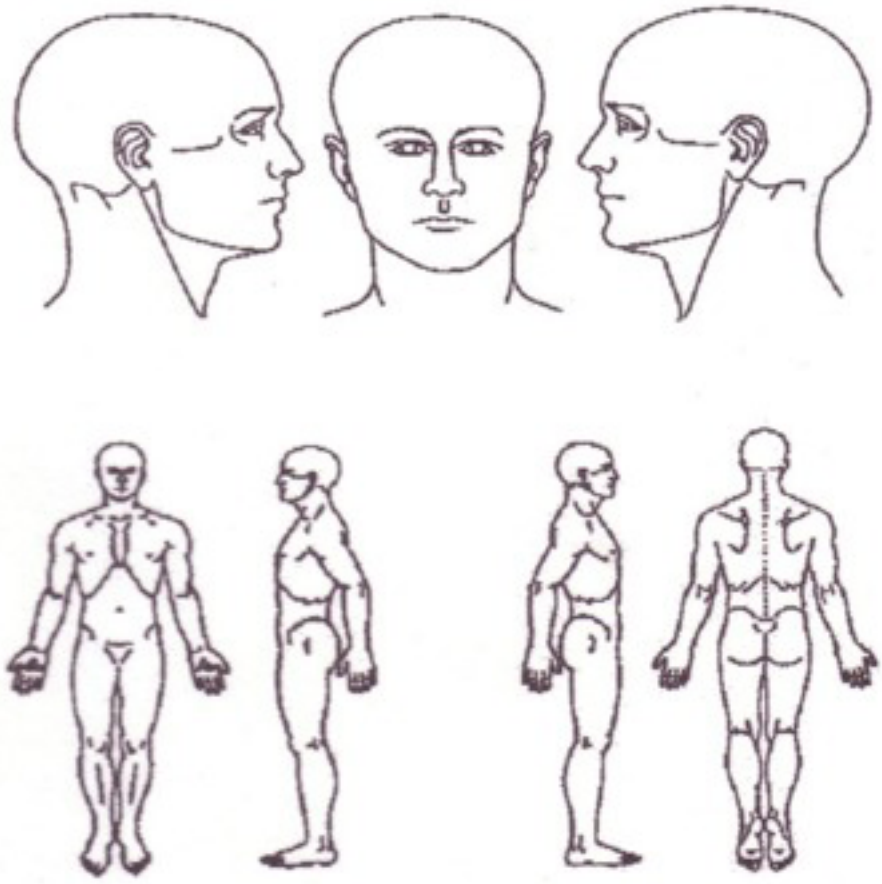
No Problem Worst Imaginable

**Please note the greatest degree of severity of your problem within the last week:**

0 1 2 3 4 5 6 7 8 9 10

No Problem Worst Imaginable

**Please indicate areas of pain or distress:**



**Comments:**_____

I have stated all medical conditions that I am aware of and will keep my practitioner informed of any changes.

Name _____

Signature_____ Date _____