HEALTH HISTORY QUESTIONNAIRE

Welcome to the Acupuncture Herb Center of Wayne. Please help us provide you with a complete evaluation by taking the time to fill out this questionnaire carefully. All your answers will help absolutely confidential. If you have questions, please ask. Thank you.

Last Name: First Name: Date:

Street: City State Zip

Home Phone: Work Phone: Cell:

Date of Birth: Social Security Number:

Age: Height: Weight:

Occupation: Marital Status:

E-mail: Referred by:

In case of emergency notify: Phone number:

Family Physician:

Policy Holder & Date of birth:

Have you tried Acupuncture of 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 diagnosis for the problem by a physician or chiropractor?

if so, what is it?

What kinds of treatment or therapy have you tried?

PAST MEDICAL HISTORY (PLEASE INCLUDE DATES)

- ☐ Allergies
- ☐ Cancer
- ☐ Diabetes
- ☐ Hepatitis
- ☐ High blood pressure
- ☐ Heart disease
- ☐ Seizure
- ☐ Rheumatic fever
- ☐ Surgeries
- ☐ Venereal disease
- ☐ Thyroid disease
- ☐ Birth trauma (prolonged labor, forceps delivery, etc)

- ☐ Other relevant medical history (describe)
- ☐ Accident or significant trauma (describe)

FAMILY MEDICAL HISTORY

☐ 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:

☐ Breakfast	☐ Lunch	☐ Dinner

Please check any of the following habits that apply. How much and how often fo you use them?

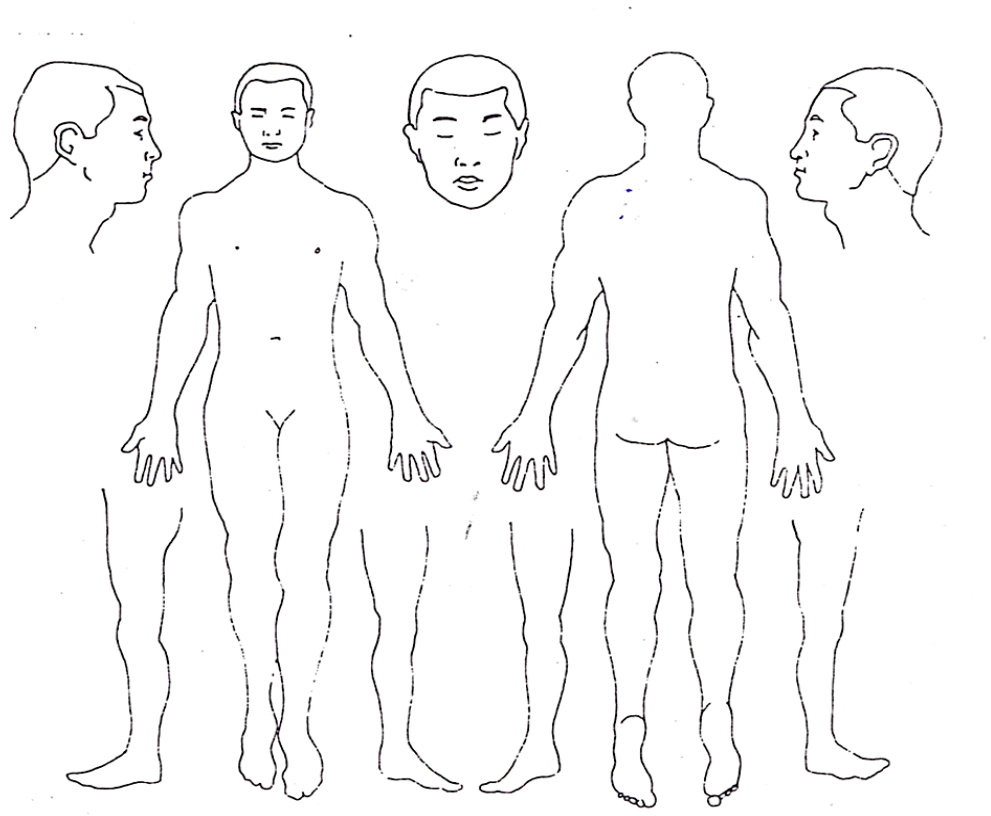
☐ Cigarette smoking ☐ Coffee, tea or cola ☐ Alcoholic beverage

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

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

PLEASE MARK PAINFUL OR DISTRESSED AREAS BELOW

△ Mild ○ Moderate X Strong



PLEASE PUT A CHECK NEXT TO ANY CONDITIONS YOU HAVE EXPERIENCED WITHIN THE LAST THREE MONTHS. INDICATE THE LENGTH OF TIME YOU HAVE HAD THIS CONDITION

GENERAL

- ☐ Poor appetite
- ☐ Insomia
- ☐ Disturbed sleep
- ☐ Localized weakness
- ☐ Cravings
- ☐ Strong thirst
- ☐ Weight gain
- ☐ Weight loss
- ☐ Changes in appetite
- ☐ Sweating easily
- ☐ Tremors
- ☐ Bleeding or bruising easily
- ☐ Night Sweat
- ☐ Fever
- ☐ Chills
- ☐ Sudden energy drop (time of day?)
- ☐ Poor balance

Other unusual or abnormal conditions you have noticed in general sense of health

SKIN AND HAIR

- ☐ Rashes
- ☐ Ulcerations
- ☐ Hives
- ☐ Itching
- ☐ Rashes
- ☐ Pimples
- ☐ Dandruff
- ☐ Hair loss
- ☐ Recent moles
- ☐ Changes in texture of hair or skin

Any other hair or skin problem(s)

HEAD, EYES, EARS, NOSE, THROAT

- ☐ Dizziness
- ☐ Concussion
- ☐ Migraines
- ☐ Glasses
- ☐ Spots in front of eyes
- ☐ Eye pain
- ☐ Poor vision
- ☐ Night blindness
- ☐ Color blindness
- ☐ Cataracts
- ☐ Blurry vision
- ☐ Earaches
- ☐ Ringing in ears
- ☐ Poor hearing
- ☐ Eye strain
- ☐ Sinus problem
- ☐ Recurrent sore throats
- ☐ Nose bleeds
- ☐ Grinding teeth
- ☐ Sores on lips ot tongue
- ☐ Facial pain
- ☐ Teeth problems
- ☐ Headaches (where? When?)
- ☐ Jaw clicks

Any other head or neck problem

CARDIOVASCULAR

- ☐ Dizziness
- ☐ Low blood pressure
- ☐ Chest pain
- ☐ Irregular heartbeat
- ☐ High blood pressure
- ☐ Fainting
- ☐ Cold hands or feet
- ☐ Swelling of hands
- ☐ Swelling of feet
- ☐ Blood clots
- ☐ Difficulty in breathing
- ☐ Phlebitis

Any other heart or blood vessel problems

RESPIRATORY

- ☐ Cough
- ☐ Coughing up blood
- ☐ Asthma
- ☐ Bronchitis
- ☐ Pain with deep inhalation
- ☐ Pneumonia
- ☐ Difficulty breathing when lying down
- ☐ Excessive phlegm (color?)

Any other lung problem

DIGESTIVE

- ☐ Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Gas
- ☐ Belching
- ☐ Black stools
- ☐ Blood stools
- ☐ Indigestion
- ☐ Bad breath
- ☐ Rectal pain
- ☐ Hemorrhoids
- ☐ Abdominal pain or cramps
- ☐ Chronic laxative use

Any other problems with stomach or instestines

GENITOURINARY

- ☐ Pain on urination
- ☐ Frequent urination
- ☐ Blood in urine
- ☐ Sores on genitals
- ☐ Urgency to urinate
- ☐ Unable to hold urine
- ☐ Kidney stones
- ☐ Decrease in flow
- ☐ Urgency to urinate
- ☐ Impotency

Do you wake up at night to urinate?_____ If so, how often?_____

REPRODUCTIVE and GYNECOLOGIC (Women only)

- ☐ Clots
- ☐ Painful menses
- ☐ Irregular menses
- ☐ Change in body/psyche prior to menstruation
- ☐ Heavy/light

Age at first menses Age of menopause First day of last menses

Number of pregnancy Miscarriages Abortions Number of birth

Do you practice birth control? If so, what type? For how long?

Any other gynecologic problem(s)

MUSCULOSKELETAL

- ☐ Neck pain
- ☐ Muscle pains
- ☐ Knee pain
- ☐ Back pain
- ☐ Muscle weakness
- ☐ Foot/ankle pains
- ☐ Hand/wrist pains
- ☐ Shoulder pains
- ☐ Hip pain

Any other joint or bone problem(s)

NEUROPSYCHOLOGICAL

- ☐ Seizures
- ☐ Dizziness
- ☐ Loss of balance
- ☐ Areas of numbness
- ☐ Poor memory
- ☐ Lack of coordination
- ☐ Concussion
- ☐ Depression
- ☐ Anxiety
- ☐ Bad temper
- ☐ Easily susceptible to stress

Have you ever been treated for emotional problem(s)?

Have you ever considered or attempted suicide?

Any other neurological or psychological problem(s)?

PLEASE LIST ANY OTHER PROBLEMS YOU WOULD LIKE TO DISCUSS