HEALTH HISTORY QUESTIONNAIRE

Each of us is unique, not the same as anyone else. That is why our treatment is best approached by considering you individually according to your particular history and symptom patterns.

These questions are designed to help obtain as complete a picture as possible. If you have any questions about how to answer, or if you don't want to answer a particular question or section, feel free to leave it for now and we can discuss it during our interview.

All information will remain strictly confidential and will not be released without your written consent. Thank you for taking the time to fill out this detailed form.

General Patient Information email: _____

Name: _____ Date: ____/____/____

Full Address: _____

Phones: Cell_____ Work_____ Home_____

Age: _____ Date of Birth: ____/____/_____ Place of Birth: _____

Parent or Guardian (if under 18): _____

Gender: _____ Height: _____ Weight: _____lbs.

Occupation:_____ Employer:_____

How did you hear about our office?_____

What are your major complaints, in order of significance to you, and when did each begin?

_____

_____

_____

_____

Have you been given a medical diagnosis for any of these? If so, what? _____

_____

To what extent do these interfere with your daily activities (work, sleep, etc.?) _____

_____

Family Health History

	Living?	Age	General Health	Age at Death	Cause of Death
Mother:					
Father:					

Please note whether your Father (**F**), Mother (**M**), Grandparents (**GM/GF**), or Sibling (**S**) were known to have any of the following:

____ Asthma	____ Arthritis	____ Allergies	____ Alcoholism
____ Cancer or Tumor	____ Colitis	____ Depression	____ Diabetes
____ Epilepsy	____ Heart Disease	____ Kidney Disease	____ Migraine
____ Mental Illness	____ Nervous Breakdown	____ Obesity	____ Stroke
____ Suicide	____ Tuberculosis	____ Thyroid Condition	Other _____

Your Health History

How was your childhood health?_____

Hospitalizations, surgeries, and major illnesses and approximate dates: _____

_____

_____

_____

Describe any serious injuries or accidents you've had and the year they occurred: _____

_____

Have you ever been treated with acupuncture or Chinese herbal medicine? ___No ___Yes When? _____

Nature of complaint: _____ Results: _____

What medications are you currently taking? Be sure to also include any birth control pills, hormones, and over-the-counter meds. _____

_____

_____

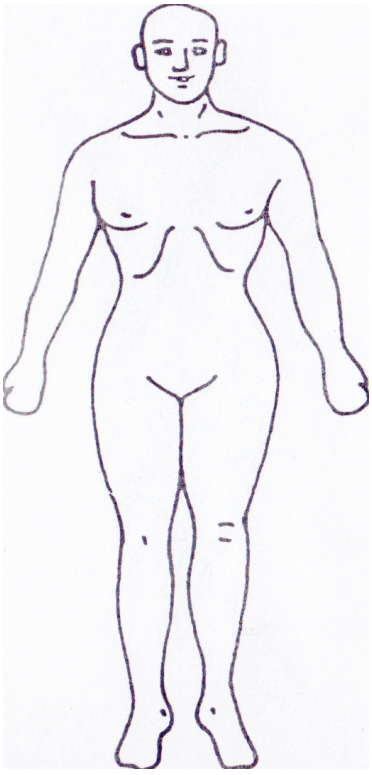
_____

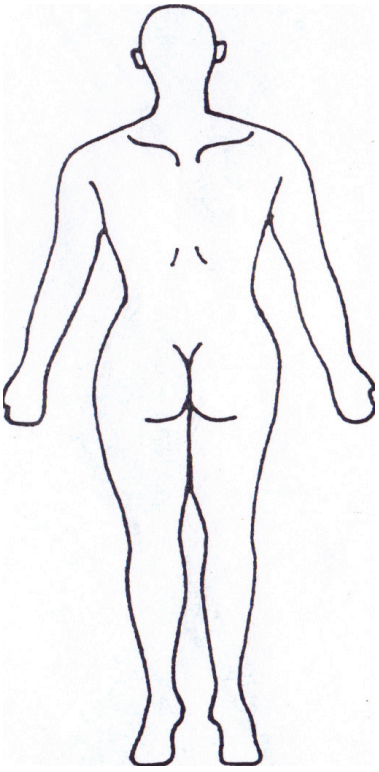
Please also list any that you were taking regularly until recently: _____

_____

Please mark on the person below to show where you experience **P**AIN**,** **N**UMBNESS, or **T**INGLING.

For pain, you may indicate whether it is **S**HARP, **B**URNING, **A**CHING, **C**RAMPING, **D**ULL, or **TH**ROBBING. Also, please show where you have any major SCA**R**S





Please note below any symptoms that you have now or had in the past with this key:

1. **Write an "N" by the symptom if you have it Now, AND/OR**
2. **Write an "R" by any symptoms you had in the Recent past** (i.e., past 3 months)**, AND/OR**
3. **Write a "P" if you had a symptom in the Past more than 3 months ago and it was a *significant* part of your health picture then. Note how long ago this bothered you.**

For example: **N R** Cough means that you have a cough now and you've had a cough in the recent past.

Feel free to write any explanatory notes next to the symptoms.

According to Chinese Medicine, if you have symptoms in the following categories, it indicates that you may have a problem with that organ's energetic function.

Overall Temperature (Kidney energetic function):

_____Cold hands or feet
_____Sweaty hands or feet
_____Hot body temperature (sensation)
_____Cold body temperature (sensation)
_____Afternoon flushes
_____Night sweats
_____Heat in the hands, feet, and chest
_____Hot flashes any time
_____Often thirsty
_____Perspire easily
_____Lack of perspiration
_____Take water to bed

Overall energy (Lung, Kidney energetic function):

_____Shortness of breath
_____Difficulty keeping eyes open in the daytime
_____General weakness
_____Easily catch colds
_____Low energy
_____Feel worse after exercise

Blood (Liver, Spleen, Heart energetic function):

_____Dizziness
_____See floating black spots
_____Dry skin or hair
_____Lose balance easily

Heart energetic function:

_____Palpitations
_____Anxiety
_____Panic attacks
_____Sores on the tip of the tongue
_____Restlessness
_____Mental confusion
_____Chest pain traveling to shoulder
_____Difficulty sleeping/insomnia
_____Wake unrefreshed

Lung energetic function:

_____Nasal discharge or congestion
_____Cough
_____Nose bleeds
_____Sinus congestion
_____Dry mouth, throat, or nose
_____Decreased sense of smell
_____Skin problems
_____Allergies
To what? _____
_____Sneezing
_____Stiff neck or shoulders
_____Sore throat
_____Difficulty breathing/shortness of breath
_____Bronchitis
_____Pneumonia
_____Sadness, melancholy
_____Anxiety

Please mark symptoms with N (Now), and/or R (Recently), and/or P (in Past more than 3 mo. ago).

Spleen energetic function:

_____Low appetite
_____Abrupt weight gain
_____Abrupt weight loss
_____Abdominal bloating, gas
_____Fatigue after eating
_____Easily bruised
_____Prolapsed organ (diagnosed)
which organ? _____
_____Hemorrhoids
_____Pensive
_____Over-thinking or worrying

Spleen, Stomach, Large/Small Intestine function:

How often do you have bowel movements?

_____

Do they tend to be normal, loose, or very hard?

_____

_____Loose stool
_____Constipated
_____Diarrhea
_____Blood in stools
_____Mucous in stools
_____Undigested food in stools
_____Need laxatives

Dampness trapped in the body:

_____General sensation of heaviness in the body
_____Mental sluggishness or fogginess
_____Swollen hands
_____Swollen feet
_____Swollen joints
_____Chest congestion
_____Nausea
_____Snoring

Stomach energetic function:

_____Excessive appetite
_____Bad breath
_____Mouth (canker) sores
_____Bleeding, swollen or painful gums
_____Heartburn, acid regurgitation
_____Ulcer (diagnosed)
_____Belching
_____Gas
_____Stomach pain
_____Nausea
_____Vomiting
_____Feel like digestion is sluggish

Liver, Gall Bladder energetic function:

_____Alternating diarrhea and constipation
_____Chest pain or tightness
_____Pain or tightness under ribs
_____Bitter taste in the mouth
_____Irritable, easily angered
_____Frustration
_____Depression
_____Frequently feel unable to adapt to stress
What causes the stress?_____
_____Skin rashes or itchiness
_____Headache at the top or side(s) of the head
_____Migraines
_____Tremors
_____Muscle spasms, twitching, cramping
_____Seizures
_____Feeling of a lump in the throat
_____Neck tension, stiffness
_____Shoulder tension, stiffness
_____High-pitched ringing in the ears
_____Gall stones
_____Menstrual difficulties or PMS
_____Sexually transmitted disease
(which?_____)

Please mark symptoms with N (Now), and/or R (Recently), and/or P (in Past more than 3 mo. ago).

Eyes (Liver energetic function):

_____Itchy
_____Bloodshot
_____Hot
_____Dry
_____Watery
_____Gritty
_____Blurry vision
_____Decreased night vision
_____Near-sighted or far-sighted

Kidney, Urinary Bladder energetic function:

_____Frequent cavities
_____Easily broken bones
_____Sore knees
_____Weak knees
_____Low back pain
_____Memory problems
_____Excessive hair loss
_____Wake during the night twice or more to urinate
_____Fearful
_____Easily startled
_____Bladder infections
_____Kidney stones
_____Low-pitched ringing in the ears

Urination:

_____Normal color
_____Reddish or dark yellow
_____Burning or painful
_____Cloudy
_____Scanty
_____Profuse
_____Unable to hold urine
(mild or severe? _____)
_____Urgent
_____Frequent

Libido:

_____Normal
_____High
_____Low

Urology:

_____Prostate trouble
_____Testicular pain or swelling
_____Urine stream weak or slow

Gynecology:

_____Pelvic Inflammatory Disease
_____Infertility
_____Endometriosis
_____Ovarian cysts
_____Yeast infections
_____Uterine fibroids
_____Fibrocystic breasts

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Do you have **headaches or migraines** ?

Where on your head? _____

How often? _____

What triggers them? _____

_____

Sleep

Usual time you go to sleep_____. Usual time you wake up_____

Do you have a hard time falling asleep? _____.

Do you wake up during the night? _____. If yes, how often, or at what times? _____

Do you fall asleep again quickly? _____

Do you have disturbing dreams often? _____

Do you usually wake up feeling refreshed?_____

Diet, Habits

Do you have:

_____Coffee? Number of cups per day: _____

_____Soda? Is it caffeinated? _____ Is it "diet"? _____ # cans per week: _____

_____Artificial sweeteners? How often? _____

_____Alcohol? How much, how often? _____

If you quit, how long ago? _____

_____Cigarettes? How many per day? _____. If you quit, how long ago? _____

_____Marijuana? How frequently? _____. If you quit, how long ago? _____

_____Other recreational drugs? Which and how often?_____

If you quit, how long ago?_____

Do you eat at regular times? _____. How much water do you usually drink in a day? _____

Do you eat beef?_____ poultry?_____ fish?_____ eggs?_____

What do you eat in a typical day?_____

_____

_____

_____

Do you get regular exercise? Please describe:

_____

_____

Neuropsychological -- Please also indicate approximate **dates** for any "yes" answers:

Have you ever been treated for emotional problems? _____

Have you ever had a nervous breakdown? _____

Have you ever considered or attempted suicide? _____

Any other neurological or psychological problems? _____

GYNECOLOGY PAGE

Date of last menstrual period _____

How many days does your period last? _____ How many days in your monthly cycle? _____

Bleeding or spotting between periods? ____yes ____no If yes, when? _____

If your periods cause you considerable difficulty or pain, please describe: _____

_____

Do you experience any of the following symptoms of PMS?

____Anxiety ____Irritability ____Mood swings ____Water retention
____Breast pain or swelling ____Bloating ____Depression ____Food cravings

How many days before your period does the PMS start?_____.

Please fill in the following chart for an average menstrual flow:

	Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7
Color (normal, bright red, pale, brown, rust, dark, purple, other)							
Amount of flow (normal, heavy, light)							
Pain/cramps (location, dull, sharp, other)							
Clots (how big?)							
Vomiting (check if yes)							
Nausea (check if yes)							
Other							

Please note for how many days you experience any of the following in association with your period:

	Before period	After period
Cramping	_____	_____
Backache	_____	_____
Fatigue	_____	_____

Do you have headaches or migraines associated with your menstrual cycle? If yes, when do the headaches occur?

_____

Number of: Children? _____ Their ages: _____

Miscarriages, still births, abortions? _____

Please describe any medical complications with any of the pregnancies:_____

_____

Do you have regular PAP tests? _____. Date of last PAP test?_____

If you practice birth control, what kind? _____

Age at menopause_____. If any symptoms, please describe: _____

For everyone:

Please indicate approximate dates and briefly describe the nature of any traumatic experiences you've had (for example, divorce, change of residence, death in family, bankruptcy, etc.). We ask this because these types of stress often contribute to health problems.

Date	Event
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Is there anything else I should know about you? Please provide any other information about yourself or any condition that was not covered by the questions above. _____

_____

_____

Patient Signature:_____ Date: _____