Acupuncture Health History Questionnaire

Name:	DOB:	Age:	Height:	Weight:

Address:

City: State: Zip:

Email:	Have you tried acupuncture? Y / N

Phone#: Cell Phone#:

Occupation: Marital Status:

Emergency Contact Name:
Emergency contact Phone#:

Who may we thank for referring you?

Recent Health Care Providers: Name, Date, Service Provided:

What is your Main Concern?

When did you first notice symptoms?

If you have been diagnosed, what is diagnosis?

What kinds of treatments/therapies have you tried?

Hospitalizations/Surgeries/Accidents: (please list and give approximate date)

Allergies:

Family Health History

Family Member:	Age:	Important Diseases/Illnesses	Deceased Y/N

Lifestyle

Exercise	☐ Sedentary (No exercise)
	☐ Mild exercise (i.e., climb stairs, walk 3 blocks, golf)
	☐ Occasional vigourous exercise (less than 4x/week for 30 min)
	☐ Regular vigourous exercise (more than 4x/week for 30 min+)
Diet	Are you dieting? ☐ Yes ☐ No
	If yes, are you on a physician prescribed diet ☐ Yes ☐ No
	What is the number of meals you eat in a given day?
	Describe daily diet:

Caffeine/ Alcohol/ Drugs/ Tobacco	Indicate # of cups/cans per day ☐Coffee ____ ☐Tea ____ ☐Soda ____		
	☐ Tobacco _______________ *(type and times per day)* # of Years ________		
	Do you drink alcohol? ☐ Yes ☐ No		
	If so, how many drinks per week?		
	Do you use recreational drugs? If yes, what type?		
Personal History *Please check all that apply*			
General	☐Poor appetite	☐Weight gain	☐Night sweats
	☐Insomnia	☐Weight loss	☐ Fever
	☐Disturbed sleep	☐Sweating easily	☐Chills
	☐Localized Weakness	☐Bleeding/Bruising	☐Sudden energy drop
	☐Craving sugar	☐Craving Salt	☐Poor balance
	☐Strong thirst	☐Chewing ice	☐ Tremors
Skin and Hair	☐Rashes	☐Eczema	☐Recent moles
	☐Ulcerations	☐Pimples/acne	☐Changes in hair texture
	☐Hives	☐Dandruff	☐Hair loss
	☐Itching	☐Significant scarring	
Head, Eyes, Ears, Nose, Throat, Teeth	☐Dizziness	☐Color Blindness	☐Recurrent sore throats
	☐Concussions	☐Cataracts	☐Nose bleeds
	☐Migraines	☐Blurry vision	☐Grinding teeth
	☐Glasses	☐Earaches	☐Sores on lips or tongue
	☐Spots in front of eyes	☐Ringing in ears	☐Facial pain
	☐Eye pain	☐Poor hearing	☐Teeth problems
	☐Poor vision	☐Eye strain	☐Headaches
	☐Night blindness	☐Sinus problems	☐Jaw clicks
	☐Photophobia	☐Cavities	☐Gum problems
Heart and vascular health	☐Dizziness	☐ High B.P.	☐Swelling of feet
	☐Low B.P	☐ Fainting	☐Blood clots
	☐Chest pain	☐ Cold hands/feet	☐ Difficulty breathing
	☐Irregular heartbeat	☐Swelling of hands	☐ Phlebitis
	☐Tightness in chest	☐Palpitations	☐Stroke
Respiratory	☐Cough	☐ Bronchitis	☐Frequent colds/flu
	☐Asthma	☐Shortness of breath	☐ Excessive phlegm
Digestive system	☐Nausea	☐ Belching	☐ Rectal pain
	☐Vomiting	☐ Black stools	☐Hemorrhoids
	☐Diarrhea	☐Blood in stools	☐Abdominal pain/cramps
	☐Constipation	☐ Indigestion	☐Chronic laxative use
	☐Gas/bloating	☐ Bad breath	☐Crohn's
	☐Parasites	☐Diverticulitis	☐Colitis
Urinary	☐Pain on urination	☐ Incontinence	☐Prolapse

	☐Urinary infections	☐Decreased flow	☐Kidney stones
	☐Blood in urine	☐ Frequent urination	
Muscular & Skeletal	☐Neck pain	☐Back Pain	☐Hand/wrist pain
	☐Muscle pain	☐ Muscle weakness	☐ Shoulder pain
	☐Knee pain	☐Hip pain	☐Foot/ankle pain
	☐Sciatica	☐Tinnitus	☐Arthritis
	☐Loss of sensation	☐Restless legs	☐Disc problems
Nervous System & Mental Health	☐Seizures	☐Poor memory	☐Anxiety
	☐Dizziness	☐Depression	☐Bad Temper
	☐Loss of balance	☐Frequent mood swings	☐ Panic attacks
Other Illnesses	☐HIV positive	☐AIDS	☐Lyme disease
	☐Mononucleosis	☐Diabetes	☐Cancer
	☐Hepatitis	☐Eating disorder	☐ Autoimmune disease

Female Reproductive and Sexual Health	
Age at onset of menstruation: Date of last menstruation:	
Period occurs every _______ days	
Heavy periods, irregularity, spotting, pain, discharge?	☐ Yes ☐ No
Menstrual tension, pain, bloating, irritability, or other symptoms with period?	☐ Yes ☐ No
Number of pregnancies: ______ Number of live births: ______	
Are you currently pregnant or breastfeeding?	☐ Yes ☐ No
D&C, Hysterectomy, or Cesarean?	☐ Yes ☐ No
Breast tenderness, lumps, nipple discharge?	☐ Yes ☐ No
Do you experience pain on intercourse? Y/N Do you experience low/no sex drive? Y/N	
History of sexual abuse? Y/N History of STD infection? Y/N	

Male Reproductive and Sexual Health	
Recent kidney, bladder, or prostate infections?	☐ Yes ☐ No
Problems emptying bladder completely?	☐ Yes ☐ No
Difficulty with erection or ejaculation?	☐ Yes ☐ No
Testicle pain or swelling?	☐ Yes ☐ No
BPH or chronic prostatitis?	☐ Yes ☐ No
Do you experience low/no sex drive?	☐ Yes ☐ No
History of sexual abuse? Y/N History of STD infection? Y/N	

Please list all medications, herbs, and supplements you are currently taking:

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Patient (or guardian) Signature ________________________________ Date: ____________