HEALTH HISTORY QUESTIONNAIRE
Information for your Acupuncturist

Important: Complete this document as thoroughly as possible. Some of the questions that follow may seem unrelated to your condition, but they may play a major role in diagnosis and treatment.
All information is strictly confidential.

I. General Patient Information

Date: ____/____/____

Name: _____

Address: _____

City, State, Postal Code: _____

Cell Phone: (_____)_____ Alternative Number: (_____)_____

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

Emergency Contact: Phone Number (_____)_____

Name and Relation: _____

Guardian (if under 18): _____

Gender: □M □F Height: ____'____" Weight: _____lbs.

E-Mail:_____

Occupation: _____Employer:_____

How did you hear about our office? _____

Major Complaint(s), in order of significance to you:

1. _____ 4. _____
2. _____ 5. _____
3. _____ Additional:_____

How do these conditions impair your daily activities?_____

_____

II. Patient Medical History

How was your childhood health?_____

Hospital Visits/Stays:_____

Recent tests: (please indicate test results and date below)

□Physical □Cholesterol □Prostate □Blood (which?)
□HIV/STD □Pap smear □Mammography
□Other:_____

Test Results and Date:_____

Check any you have had in the past:

□Diabetes	□Allergies	□Glaucoma	□Rheumatic Fever
□Heart Disease	□CVA (stroke)	□Vein condition	□Thyroid disorder
□Asthma	□Pneumonia	□Tuberculosis	□Emphysema
□Jaundice	□Gonorrhea	□Mumps	□Bleeding tendency
□Syphilis	□Measles	□Chicken pox	□Nervous disorder
□Meningitis	□HIV	□Polio	□Mononucleosis
□Epilepsy	□High fever	□Hepatitis	□Multiple Sclerosis
□Paralysis	□Cancer	□Migraines	□High blood pressure
□other lung illnesses	□other liver illnesses	□other heart illnesses	□other kidney illnesses

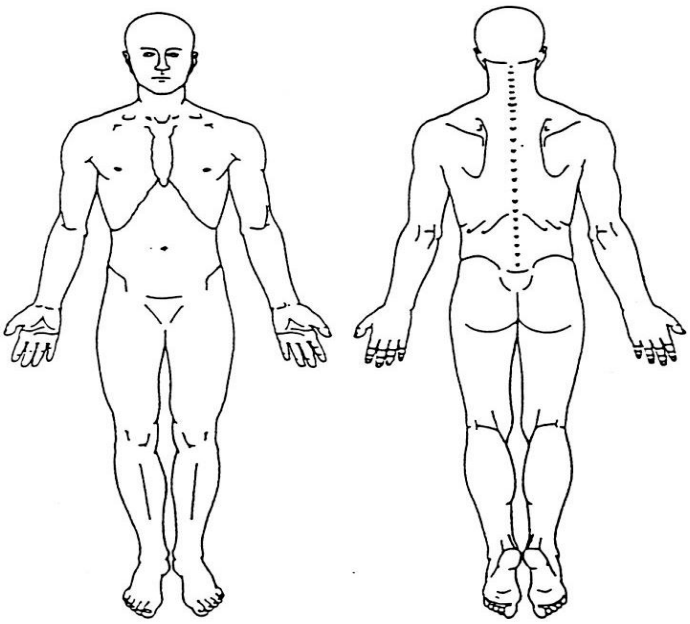
□other:_____
_____

Immunizations:_____

Surgeries:_____

III. **Patient Profile**

Please clearly mark any areas of pain and any scars (please indicate which of the areas are scars):



Is the pain:
- □ Sharp?
- □ Burning?
- □ Dull?
- □ Aching?
- □ Cramping?
- □ Moving?
- □ Fixed?
- □ Other_____

Do the following lessen the pain?
- □ Pressure □ Heat
- □ Cold □ Exercise
- □ Other_____

Do the following worsen the pain?
- □ Pressure □ Heat
- □ Cold □ Other:_____

Women only:

Regular menstrual cycle? □Y □N Pregnant? □Y □N Clots? □Y □N
Number of children:_____ Number of pregnancies:_____
Age of first menstruation:_____ Age of menopause (if applicable):_____
Average number of days of flow:_____ Average number of days of entire cycle:_____
□Vaginal discharge □Bleeding between periods

Do you experience any of the following pre-menstrual syndromes?

□nausea □vomiting □water retention □breast swelling
□food cravings □headaches □migraines □breast tenderness
□depression □irritability □anxiety □other emotions:_____
□dull pain, where?_____ □sharp pain, where?_____

Men only:

□Swollen testes □Testicular pain □Impotence □Premature ejaculation
□Feeling of coldness or numbness in external genitalia □Other_____

Personal Physician:_____ **Phone Number &/or Practice Name**:_____

Medication/Herb	Amount	How long?	By Doctor (Y/N)	By Practioner (Y/N)	Self (Y/N)	Comments

All please fill out:

These statements above are true to the best of my knowledge

Patient Signature:_____ Date: _____

Office Signature:_____ Date: _____

For Office Use: □ Healing Reactions sheet given □ Copy of Policies given □ Health Information sheet given

Patient Policies:

Your health and wellness is a joint effort between you and the acupuncturist. We are dedicated to making you healthy and we will do our part by being available and knowledgeable. For the best results it is important to come as often as the acupuncturist determines for your treatment plan and to follow the acupuncturist's advice for how to take care of your body between appointments.

Appointments and Payment: _____(initials)

1.) Please arrive 5 to 10 minutes early for your appointment. If you are 10-15 minutes late there is a significant chance that you could lose your appointment time. You may reschedule, if we have time available, later that day or another time. If you do not reschedule with in that same week, you are required to pay for the appointment.
2.) If an appointment is canceled less than 24 hours in advance you will be charged the office visit rate ($40.00) for the missed appointment. If you fail to show up, you will be charged the office visit rate ($40.00) for the missed appointment.
3.) Our Policy is that payment is due at the time of service. As an alternative, we offer a package deal.

Dress Code: _____ (initials)

4.) Acupuncture points used for your treatment will determine what areas of the body that needs to be exposed. Please wear appropriate clothing, such as loose pants that can be moved above the knee, for both men and women. Please wear loose fitting shirts that can be moved to expose the lower or upper back if necessary. We can also supply you with a gown or alternative clothing if needed. If at any time you are uncomfortable please let the front desk or acupuncturist know.

Healing Reactions: _____ (initials)

5.) Chinese medicine and *acupuncture healing reactions*—During the process of becoming well your body may go through healing reactions. This may include exacerbation of previous or existing conditions. This is not a bad sign. Your body is trying to adjust to the positive changes and the **symptoms may increase before they diminish**. Please inform our office of these changes so that they can be addressed and your treatment plan can be adjusted accordingly.

Frequency:_____ (initials)

To establish an individual treatment baseline it is highly recommended that you return for 4-5 visits within the first two weeks of your initial consultation.

Are you interested in taking herbal medication or herbal remedies? Yes___ No_____

Patient Signature_____ Date _____

Office Signature_____ Date_____