

Health History Questionnaire

Date: ___ / ___ / ___

Name:		Gender: M F	Age:
Address:		City:	State: Zip Code:
Home Phone:		Cell Phone:	Email:
Date of Birth:	Place of Birth:	Height:	Weight:
		Relationship Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Living w/partner <input type="checkbox"/> Other	
Employer:		Occupation:	
Physician:		Physician's Phone #:	
Emergency Contact Name:		Emergency Contact Phone:	
Referred By:		Have you been treated by Acupuncture or Oriental Medicine Before? <input type="checkbox"/> No <input type="checkbox"/> Yes ___ / ___ / ___	

What is your main complaint today?

When did this problem begin? (Please be specific)

What do you think caused it? Is the cause still present?

What treatments have you tried already? What were the results?

Have you been given a diagnosis for this problem? If so, what?

To what extent does this problem interfere with your daily activities? (work, sleep, eating...)

How severe is your problem right now? (Please mark the scale below)

No problem	Moderate	Worst Imaginable

What's the most severe level you have endured within the last week? (Please mark the scale below)

No problem	Moderate	Worst Imaginable

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Past Medical History (please indicate by date(s):

Cancer _____ High Blood Pressure _____ Rheumatic Fever _____ Venereal Disease _____
Diabetes _____ Heart Disease _____ Seizures _____ Allergies _____
Hepatitis _____ Stroke _____ Thyroid Disease _____ Pacemaker _____
Other: _____

Surgeries (type and date): _____

Significant Trauma (auto accidents, falls, etc.): _____

Significant Dental Work (type and date): _____

Birth History (prolonged labor, forceps delivery, caesarian section, other): _____

Allergies (drugs, chemicals, foods, animals): _____

Family Medical History

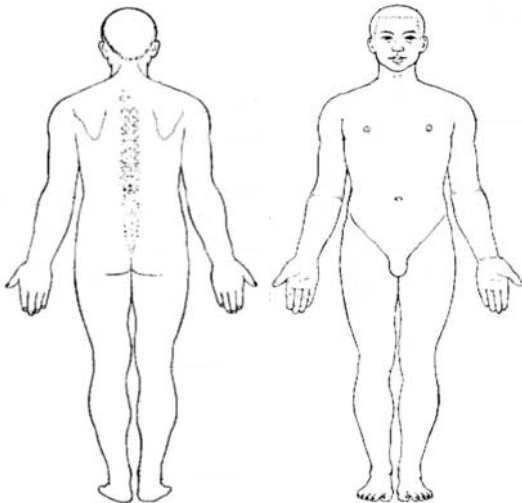
[] High Blood Pressure [] Alcoholism [] Cancer: [] Allergies:
[] Heart Disease [] Seizures _____
[] Arteriosclerosis [] Asthma _____
[] Stroke [] Diabetes _____

Occupational Stress (chemical, physical, psychological, etc.): _____

Do you exercise regularly? Y or N Please describe: _____

Comments (please list any other problems you would like to discuss): _____

Indicate Painful or Distressed Areas



What are Your Treatment Goals?

- [] Temporary relief of symptoms/pain control
[] Eliminate root or cause of problem (if possible)
[] Lessen/eliminate habits which caused the condition or made it worse
[] Maintenance care (periodic balancing/tune-up to keep in good health)

On the following page, please check any boxes of symptoms you have had in the past month. [Arrow pointing right]

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General

- Chills, Fevers, Sweat easily, Night sweats, Localized weakness, Bleed or bruise easily, Peculiar tastes or smells, Strong thirst (cold / hot), Thirst, no desire to drink, Fatigue, Sudden energy drop, Edema, Poor sleeping, Tremors, Poor balance, Cravings, Change in appetite, Poor appetite, Weight change

Skin and Hair

- Rashes, Itching, Change in hair or skin, Ulcerations, Eczema, Oozing skin lesion, Hives, Pimples, Recent moles, Loss of hair, Dandruff

Head, Eyes, Ears, Nose, and Throat

- Dizziness, Migraines, Headaches, Facial pain, Glasses, Poor vision, Night blindness, Blurry vision

- Color blindness, Blind field, Spots in front of eyes, Eye pain, Eye strain, Cataracts, Eye Dryness, Excessive tearing, Discharge from eyes, Poor hearing, Ringing in ears, Earaches, Discharge from ear, Nose bleeds, Sinus congestion, Nasal drainage, Grinding teeth, Teeth problems, Jaw clicks, Concussions, Recurrent sore throats, Hoarseness, Sores on lips/tongue

Cardiovascular

- High blood pressure, Low blood pressure, Chest discomfort/pain, Heart palpitations, Cold hands or feet, Swelling of hands, Swelling of feet, Blood clots, Fainting, Difficulty in breathing

Respiratory

- Cough, Asthma/wheezing, Difficulty in breathing when lying down, Phlegm, Coughing blood, Pneumonia, Bronchitis

Gastrointestinal

- Bad breath, Nausea, Vomiting, Heartburn, Belching, Indigestion, Diarrhea, Constipation, Chronic laxative use, Blood in stools, Black stools, Abdominal pain/cramps, Gas, Rectal pain, Hemorrhoids

Genito-Urinary

- Pain on urination, Urgency to urinate, Frequent urination, Blood in urine, Decrease in flow, Dribbling, Kidney stones, Impotency, Change of sexual drive, Sores on genitals

Pregnancy and Gynecology

- # of pregnancies, # of births, # premature births, # of miscarriages, # of abortions, Age at first menses, Length of full cycle, Length of menses, Last menses start date, Last Pap smear

- Heavy periods, Light periods, Painful periods, Irregular periods, Changes in body/psyche prior to menstruation, Clots, Vaginal discharge, Menopause, Postcoital bleeding, Vaginal sores, Breast lumps, Nipple discharge, Do you practice birth control?, What type and for how long?

Musculoskeletal

- Neck pain, Shoulder pain, Back pain, Elbow pain, Hand/wrist pain, Hip pain, Knee pain, Foot / ankle / heel pain, Muscle pain, Muscle weakness

Neuropsychological

- Seizures, Areas of numbness, Weakness, Sleep disorder, Concussion, Violence potential, Vertigo, Lack of coordination, Bad temper, Depression, Easily stressed, Loss of balance, Poor memory, Anxiety, Substance abuse, Have you ever been treated for emotional problems?

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Habits Please indicate below: None, Light, Moderate, or Heavy. Please add comments/quantities where appropriate

	Excessive	Moderate	Minimal	None	
Alcohol:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Coffee:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tea:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tobacco:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Drugs:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Water intake	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vitamins:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sugar Intake:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Food Intake:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Appetite:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sleep:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Exercise:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Energy Level:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stress Level:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dental problems:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Diet Please give a general description of the food you eat during a "typical" day.

Morning:

Afternoon:

Evening:

Before bed:

Between meals:

Medicine Please list all medications you are taking, and for what condition. Please include prescriptions, vitamins, over-the-counter, etc):

Medicine	For what condition
_____	_____
_____	_____
_____	_____
_____	_____

Consent for treatment

I, the undersigned, understand acupuncture to involve the use of needles, electric stimulation, TDP heat therapy, cupping, gua sha, etc. The risks, although limited, include puncturing organs in the abdomen and chest cavities and bruising. Acupuncture and/or massage therapy can affect people on all levels: physical, emotional, mental and spiritual because it works with the whole body to create balance. The duration and course of treatment varies from person to person depending on their specific condition and overall constitution. I fully understand that there is no stated or implied guarantee of success or effectiveness after a specific treatment or course of treatments.

Signature _____ Date _____