City Acupuncture and Wellness Clinic

Acupuncture Patient Health History Questionnaire

Please help us provide you with a complete evaluation by filling out this questionnaire carefully. All of your answers are strictly confidential. If there is anything you wish to bring to our attention that is not asked on this form, please note it in the Comments section. Thank you!

Name _____ DOB _____/_____/_____ [ ]M [ ] F [ ] MTW [ ] WTM

Address _____ City _____ State _____ Zip _____

Phone _____ Email _____

Emergency Contact _____

Physician Name & Phone_____

Please list your chief complaint(s) for this visit or your condition(s) in order of importance:	Date first noticed:	Indicate the severity of each symptom: None Severe	Please check the box below indicating how much of the time you feel the symptom:
1. _____	_____	0 1 2 3 4 5 6 7 8 9 10	□ 0-25% □ 26-50% □ 51-75% □ 76-100%
2. _____	_____	0 1 2 3 4 5 6 7 8 9 10	□ 0-25% □ 26-50% □ 51-75% □ 76-100%
3. _____	_____	0 1 2 3 4 5 6 7 8 9 10	□ 0-25% □ 26-50% □ 51-75% □ 76-100%

CURRENT LIFESTYLE

Have you consulted an MD, ND, DO for your reasons for this visit? [ ] Yes [ ] No MDs Diagnosis: _____

Do you exercise regularly? [ ] Yes [ ] No If yes, please describe: _____

_____

List any stress factors (physical, psychological, chemical): _____

Briefly describe your average daily diet:

_____

_____

Please check the following habits that apply. How much, how often do you use them?

□ Cigarette smoking □ Coffee, tea or cola □ Alcoholic Beverages

_____ _____ _____

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

_____

_____

List any drug use for non-medical purposes:

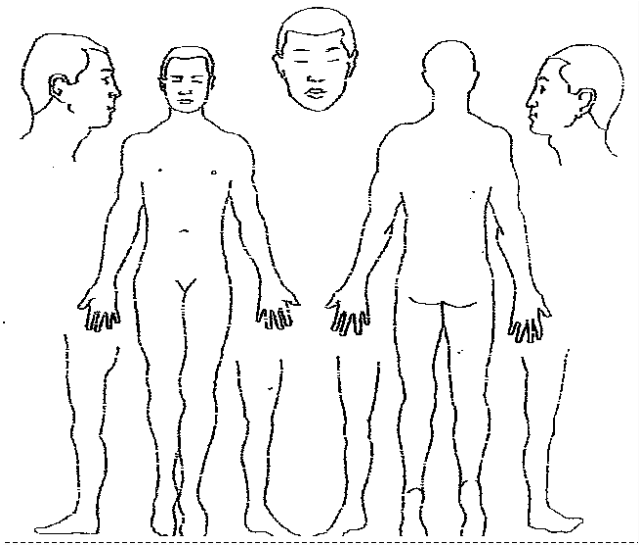
_____

_____

Have you ever had any form of counseling, therapy, interventions, etc? [ ] Yes [ ] No If yes, please describe:

_____

_____



Please mark an X for painful or distressed areas on the chart on the left. Please describe the pain:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

REVIEW OF SYSTEMS

Please put a mark [X] next to any condition you've experienced in the last three (3) months. Circle all those you've experienced in the past. Indicate the length of time you have had this condition.

GENERAL

- ☐ Poor appetite
- ☐ Insomnia
- ☐ Disturbed sleep
- ☐ Localized weakness
- ☐ Cravings
- ☐ Strong thirst
- ☐ Weight gain
- ☐ Weight loss
- ☐ Changes in appetite
- ☐ Sweating easily
- ☐ Tremors
- ☐ Bleeding or bruising easily
- ☐ Night Sweats
- ☐ Fever
- ☐ Chills
- ☐ Sudden energy drop
- ☐ Poor balance

SKIN & HAIR

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

HEAD, EYES, EARS, NOSE, THROAT

- ☐ Dizziness
- ☐ Glaucoma
- ☐ 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 problems
- ☐ Recurrent sore throats
- ☐ Nose bleeds
- ☐ Grinding teeth
- ☐ Sores on lips or tongue
- ☐ Facial pain
- ☐ Teeth problems
- ☐ Headaches
- ☐ Jaw clicks

CARDIOVASCULAR

- ☐ Nausea/Vomiting
- ☐ 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

RESPIRATORY

- ☐ Cough
- ☐ Coughing up blood
- ☐ Asthma
- ☐ COPD
- ☐ Bronchitis
- ☐ Pain with deep inhalation
- ☐ Pneumonia
- ☐ Emphysema
- ☐ Difficulty breathing laying down
- ☐ Excessive phlegm
- ☐ Shortness of breath
- ☐ Lung cancer

GASTROINTESTINAL

- ☐ Ulcers
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Mucus in stools
- ☐ Black stools
- ☐ Bad breath
- ☐ Gas/Belching
- ☐ Blood in stools
- ☐ Indigestion
- ☐ Rectal Pain
- ☐ Hemorrhoids
- ☐ Abdominal pain or cramps
- ☐ Chronic laxative use

GENITOURINARY

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

MUSCULOSKELETAL

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

NEUROPSYCHOLOGICAL

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

FEMALE ONLY: REPRODUCTIVE AND GYNECOLOGIC

- ☐ Premenstrual changes
- ☐ Heavy menstrual flow
- ☐ Lumps in breast
- ☐ Abortions
- ☐ Menstrual clots
- ☐ Light menstrual flow
- ☐ Nipple discharge
- ☐ Miscarriages
- ☐ Painful menses
- ☐ Irregular menses
- ☐ Premature births
- ☐ Other: _____
- ☐ Hot flashes

Is there a possibility you currently may be pregnant? [ ] Yes [ ] No

Age at first menses: _____ Age at menopause: _____ Number of pregnancies: _____

Time between cycles: _____ Duration of bleeding: _____ First day of last menses: _____

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

MEN ONLY

- ☐ Burning with urination
- ☐ Difficulty starting urination
- ☐ Nightly urination
- ☐ Dripping after urination
- ☐ Prostate cancer
- ☐ Impotence / ED
- ☐ Other: _____

PAST MEDICAL HISTORY (Please include dates)

- ☐ Allergies
- ☐ Cancer
- ☐ Diabetes
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Seizures
- ☐ Rheumatic Fever
- ☐ Surgeries
- ☐ Venereal Disease
- ☐ Thyroid Disease
- ☐ Birth Trauma (prolonged labor, forceps delivery, etc.)
- ☐ Heart Disease
- ☐ Suicidal ideation/Suicide attempt
- ☐ Other Significant illness/Trauma (Please describe) _____

FAMILY MEDICAL HISTORY

- ☐ Allergies
- ☐ Cancer
- ☐ High Blood Pressure
- ☐ Stroke
- ☐ Diabetes
- ☐ Heart Disease
- ☐ Seizures
- ☐ Other
- ☐ Asthma

COMMENTS

Please list any other concerns you would like to discuss:

_____

_____

_____

_____

_____