



## Patient Health History Questionnaire

NAME \_\_\_\_\_ TODAY'S DATE \_\_\_\_\_

ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ ZIP \_\_\_\_\_

PHONE: Preferred \_\_\_\_\_ Other \_\_\_\_\_

Age \_\_\_\_\_ Date of Birth \_\_\_\_\_

E-Mail \_\_\_\_\_ Would you like to receive our e-newsletter? Yes \_\_\_ No \_\_\_

Occupation \_\_\_\_\_ Employer \_\_\_\_\_

PHYSICIAN/Clinic \_\_\_\_\_

EMERGENCY CONTACT \_\_\_\_\_ Phone \_\_\_\_\_

How did you hear about us? \_\_\_\_\_

Have you previously received acupuncture? \_\_\_\_\_ Have you previously received massage? \_\_\_\_\_

Do you have a pacemaker? \_\_\_ Yes \_\_\_ No Do you wear: contact lenses? \_\_\_\_\_ hearing aid? \_\_\_\_\_

### **Main condition/s you would like to resolve**

\_\_\_\_\_  
\_\_\_\_\_

Time of Onset and Cause/s (if known) of your condition/s \_\_\_\_\_

\_\_\_\_\_

Please list any diagnoses you have been given \_\_\_\_\_

What treatments have you tried, & did they help/worsen your condition? \_\_\_\_\_

\_\_\_\_\_

### **Your Past Medical History** (please include month/year when the diagnosis was established)

Cancer \_\_\_\_\_ Hepatitis \_\_\_\_\_ Thyroid Disease \_\_\_\_\_ Seizures \_\_\_\_\_ Fibromyalgia \_\_\_\_\_ Tuberculosis \_\_\_\_\_

Hypertension \_\_\_\_\_ Blood Clots \_\_\_\_\_ Anemia \_\_\_\_\_ Arthritis \_\_\_\_\_ Breathing Problems \_\_\_\_\_ Diabetes \_\_\_\_\_

Heart Disease \_\_\_\_\_ Digestive Disorders \_\_\_\_\_ HIV/ Aids Positive \_\_\_\_\_ Venereal Disease \_\_\_\_\_ Broken Bones \_\_\_\_\_

Contagious Skin Disorder \_\_\_\_\_ Open wounds \_\_\_\_\_ Bruise easily \_\_\_\_\_ Artificial Joint \_\_\_\_\_ MS \_\_\_\_\_ Parkinson's \_\_\_\_\_

Other (please specify) \_\_\_\_\_

Surgeries / Hospitalization/Traumas (type and date) \_\_\_\_\_

\_\_\_\_\_

Allergies (including reactions to skin care products)

\_\_\_\_\_

Medicines (prescribed & non-prescribed), Herbs, Vitamins, etc. taken consistently the last two months \_\_\_\_\_

\_\_\_\_\_

**Family Medical History** (please specify family member)

Cancer                  Diabetes                  Hepatitis                  Hypertension  
Heart Disease          Stroke                  Asthma                  Alcoholism                  Miscarriage  
Psychiatric or Emotional Imbalance          Other \_\_\_\_\_

**Lifestyle Information:**

Height \_\_\_\_\_ Weight now \_\_\_\_\_ Weight one year ago \_\_\_\_\_ Weight maximum \_\_\_\_\_

Occupational Stress? (chemical, physical, psychological) \_\_\_\_\_

Describe your average week's exercise \_\_\_\_\_

Are you on a restricted diet? No \_\_\_ Yes \_\_\_ Describe \_\_\_\_\_

Cigarette Smoking (brand, quantity, & years) \_\_\_\_\_

Do any other non-medical drugs? \_\_\_\_\_

How much coffee, tea, cola & diet soda do you drink per week? \_\_\_\_\_

How much water do you drink per day? \_\_\_\_\_

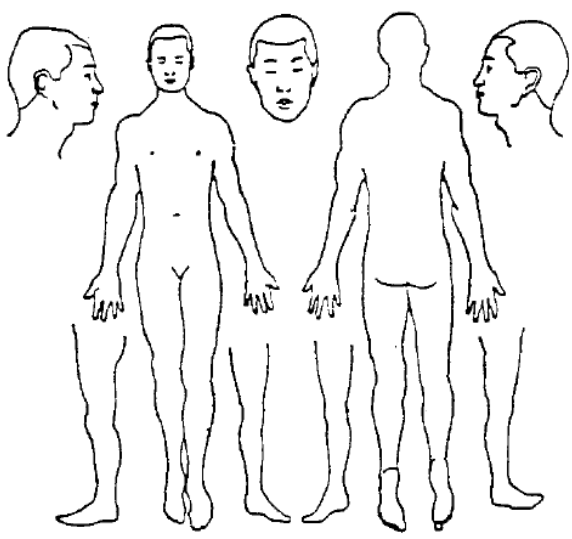
How much alcohol do you drink per week? \_\_\_\_\_

How many hours per day do you sleep? \_\_\_\_\_ Do you sleep well? \_\_\_\_\_

On average, describe your energy level on a scale of 1-10(highest) \_\_\_\_\_

List the three most significant events in your life. Are any of these situations continuing to impact your life?  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Indicate Painful or distressed areas:



Do you have any difficulty lying on your front, back, or side? Yes No  
If yes, please explain

**Please check if you have or have had in the past three months any of the following diseases or conditions.**

- Poor sleep/Insomnia
- Fatigue
- Fever
- Chills
- Night Sweats
- Sweat easily
- Bleed or bruise easily
- Strong thirst
- Sudden energy drop

**Skin/Hair**

- Rashes
- Ulcerations
- Hives
- Itching
- Shingles
- Eczema
- Pimples/Acne
- Dandruff
- Dry Skin
- Recent moles or warts
- Loss of Hair
- Changes in hair or skin
- Fungal Infections

**Musculoskeletal**

- Rheumatoid Arthritis
- Osteoarthritis
- Tendonitis
- Osteoporosis
- Weakness in muscles
- Pain in muscles
- Difficulty Walking
- Cold hand/feet
- Swelling of hand/feet
- Spinal curvature
- Hernia
- Numbness/Tingling
- Tremors
- Paralysis
- Sprain of joint

**Head, eyes, ears, nose and throat**

- Dizziness
- Concussions
- Migraines or headaches
- Eye strain or pain
- Night Blindness
- Poor Vision
- Cataracts
- Blurry Vision
- Spots in vision
- Earaches
- Ringing in ears
- Poor hearing
- Sinus problems
- Nose bleeds
- Sore throat
- Grinding teeth
- Teeth problems
- Facial pain
- Jaw clicks/ TMJ
- Sores on lips, tongues
- Difficulty swallowing

**Cardiovascular**

- High blood pressure
- Low blood pressure
- Chest pain
- Palpitations
- Fainting
- Phlebitis
- Irregular Heartbeat
- Varicose veins
- Other:

**Respiratory**

- Cough
- Coughing blood
- Wheezing
- Difficulty breathing
- Bronchitis
- Pneumonia
- Chest pain
- Esophageal pain
- Production of phlegm-  
what color? \_\_\_\_\_

**Gastrointestinal**

- Nausea/Vomiting
- Diarrhea
- Constipation
- Chronic laxative use
- Gas
- Belching
- Black stools
- Blood in stools
- Indigestion/GERD
- Bad breath
- Rectal pain
- Hemorrhoids
- Abdominal pain
- Gallbladder problems
- Parasites
- Poor appetite
- Cravings
- Crohn's
- Irritable Bowel/Colitis
- Peculiar taste

**Neurological- Psychological**

- Loss of balance
- Lack of coordination
- Depression
- Anxiety
- Stress
- Bad temper
- Bi-polar
- Eating Disorder
- Other psychiatric  
diagnosis

