Community Acupuncture Clinic

Health History Questionnaire

All medical history information is confidential.

Referred by _____ Today's date _____

Your name _____

Home number _____ Cell Number _____

Email _____

Date of birth _____

Mailing address _____

Your medical doctor's name and phone number _____

Contact name and phone number in case of emergency _____

Major complaint, reason for visit

1) _____

2) _____

3) _____

What initiates your symptoms? _____

What makes them better? What makes them worse?

Current Complaints

Headache: location _____ frequency? _____ ☐sharp ☐dull

☐Dizziness ☐Numbness ☐Tingling

Eyes: ☐red ☐itchy ☐watery ☐blurry ☐floaters ☐other _____

Ears: ☐ringing

Neck and/or shoulder: ☐tension

Throat: ☐swollen glands ☐sore ☐phlegm

Knee: ☐pain

Back: pain ☐low ☐middle ☐upper

Personal History

Check any illness or conditions you have had in the past

- ☐ Aids/HIV
- ☐ Alcoholism
- ☐ Allergies
- ☐ Anemia
- ☐ Asthma, what kind _____
- ☐ Bleed easily
- ☐ Cancer
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Heart disease
- ☐ Hepatitis
- ☐ Herpes
- ☐ High blood pressure
- ☐ Kidney disease
- ☐ Mental disorder
- ☐ MS
- ☐ Night sweats
- ☐ Pneumonia
- ☐ Rheumatic fever
- ☐ Shingles
- ☐ Stroke
- ☐ TB
- ☐ Thyroid disorder
- ☐ Ulcers
- ☐ Vascular disease
- ☐ Other_____

Do you have a pacemaker? ☐Yes ☐No

Blood type _____

List any surgeries, serious illnesses, broken bones, hospitalizations, etc.

Are you currently taking antibiotics? ☐Yes ☐No

Reason? _____ How long? _____ How often? _____

Date and result of last medical tests

Test	Date	Result
Cholesterol		
Pap smear		
Hepatitis		
Physical		
HIV		
PSA		
Other		

Emotional Health

Check any conditions you currently have or have had in the past

- ☐ Abuse
- ☐ Anxiety
- ☐ Attempted suicide
- ☐ Depression
- ☐ Irritability
- ☐ Mood swings

Current stress level? ☐Mild ☐Moderate ☐ High ☐ Extreme

Current medications and supplements (list all you are taking, since when)

_____

_____

_____

_____

Nutrition

Typical food intake

Breakfast _____

Lunch _____

Dinner, time you eat dinner _____

Snacks _____

Treats _____

Do you regularly consume Caffeine? ☐Yes ☐No Tobacco? ☐Yes ☐No Alcohol? ☐Yes ☐No

After eating, do you experience:

☐fatigue ☐bloating ☐gas ☐smelly gas ☐burping ☐pain ☐other _____

Please list any allergies or food sensitivities

_____

_____

_____

How many bowel movements do you have a day week?_____

Consistency of bowels:

☐hard ☐loose ☐diarrhea ☐cramping ☐deer pebbles ☐sticky

☐pencil like ☐alternating loose and constipated

Color of bowels ☐brown ☐light yellow ☐green

Sleep

How many hours do you regularly sleep each night?_____

Do you experience ☐trouble falling asleep ☐trouble staying asleep ☐dreaming ☐palpitations

Exercise

How often do you exercise? _____

What is your level of energy? _____

Women

Are you currently pregnant? ☐Yes ☐No

Length of cycle (days of bleeding) _____

Do you experience pain? ☐Yes ☐No If so, when ☐before ☐during ☐after

Color of flow _____

Check any conditions you experience during your menstrual cycle

- ☐ Breast tenderness
- ☐ Clots
- ☐ Cravings
- ☐ Fatigue
- ☐ Irritability
- ☐ PMS
- ☐ Sadness

Are you currently taking birth control? ☐Yes ☐No

How many times have you been pregnant? _____How many resulted in live births? _____

Check any conditions you currently have or have had in the past

- ☐ Hot flashes
- ☐ Menopause
- ☐ Miscarriages
- ☐ Night sweats
- ☐ Vaginal discharge
- ☐ Yeast infections

Please share any other information you feel would be helpful