CLINICAL
ACUPUNCTURE
SERVICES

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Health History Questionnaire

I. GENERAL INFORMATION

Name:	**Age:**
Today's date:	**Date of birth:**
Address:	
Home phone:	**Work phone:**
Cell phone:	**Email:**
Occupation:	**Referred by:**
Primary care provider:	**Oncologist:**
Emergency contact name:	**Emergency contact phone:**
Relationship status: ☐ Single ☐ Married / Partnered ☐ Divorced ☐ Widowed	

Have you ever been treated with acupuncture?	☐ Yes ☐ No	**If so, when?**	
Do you have a pacemaker?	☐ Yes ☐ No	**Any implanted electronic medical devices?**	☐ Yes ☐ No
Do you take blood thinners (e.g., Coumadin, daily Aspirin)	☐ Yes ☐ No	**How long?**	
Have you ever had Rheumatic fever?	☐ Yes ☐ No	**What age?**	
Are you pregnant?	☐ Yes ☐ No	**Any possibility that you are pregnant?**	☐ Yes ☐ No

II. PAST MEDICAL HISTORY

Check all that apply and include approximate year of diagnosis

		YEAR			YEAR
☐	AIDS / HIV		☐	Seizures	
☐	Alcoholism		☐	STDs	
☐	Arthritis		☐	Stroke	
☐	Cancer		☐	Valley Fever	
☐	Heart Disease		☐	Tuberculosis	
☐	Cataracts		☐	Bipolar Disorder	
☐	COPD		☐	Schizophrenia	
☐	Diabetes		☐	Asthma	
☐	Thyroid Disease		☐	Pneumonia	
☐	Glaucoma		☐	Chronic Fatigue Syndrome	
☐	Goiter		☐	Substance Abuse	
☐	Gout		☐	Irritable Bowel Syndrome	
☐	Hepatitis		☐	Migraine Headaches	
☐	High Blood Pressure		☐	Allergies	
☐	Fibromyalgia		☐	Other (provide details)	

III. PAST SURGICAL HISTORY / PAST TRAUMA HISTORY

List specific type and approximate year of occurrence

Surgeries:			
Traumas (this includes falls, broken bones, head injuries, auto accidents, sports injuries, etc):			
Have you ever had Whiplash?	☐ Yes ☐ No	**If so, when?**	

IV. CANCER HISTORY

Where is your cancer located?		When were you diagnosed with cancer?	
Type / Stage of your cancer?		Has your cancer spread to other parts of your body? If so, where?	
What treatments have you had for your cancer?		Are you currently receiving treatment?	
What kind of side effects/lingering impact have you experienced with your cancer treatment?			

V. LIFESTYLE

List any medications (prescribed & over-the-counter), vitamins, herbs and supplements that you are currently taking			
Name	**Dose**	**Purpose**	**How long**

V. LIFESTYLE (continued)

How frequently do you use the following substances?	
Coffee	
Soda	
Cigarettes / Tobacco Products	
Recreational Drugs	
Alcoholic Beverages	
Allergies	
Medication	
Environmental	
Food	
Are you allergic to latex?	☐ Yes ☐ No
Are you allergic to iodine?	☐ Yes ☐ No
Physical Activity (including exercise & general daily activity)	
How physically active are you each day?	☐ Inactive ☐ Slightly active ☐ Moderately active ☐ Very active
Favorite physical activity	
Diet	
How many times a day do you eat?	
Do you have any dietary restrictions?	
What kind of foods do you crave?	
Typical morning meal	
Typical afternoon meal	
Typical evening meal	
Typical snacks	
What kind of beverages do you prefer?	

VI. HISTORY OF PRESENT ISSUE

Please indicate the primary health issue for which you are seeking treatment today	
How long have you had this condition?	
How did it start?	
What medical diagnosis have you been given for this condition?	
Describe the results of any specific tests / X-rays / MRIs related to this condition	
What treatments have you received?	
What makes this condition worse?	
What makes this condition better?	
How does this condition interfere with your daily life?	

VII. TRADITIONAL CHINESE MEDICAL ASSESSMENT

(Please check all that currently apply)

Thermal Perception

- ☐ Frequently feel warm
- ☐ Frequently feel cool
- ☐ Feel warm at night
- ☐ Feel cool at night
- ☐ Have cold hands & feet
- ☐ Feel hot in my feet, chest & hands
- ☐ Have a strong thirst for cold drinks
- ☐ Have a strong thirst for hot drinks
- ☐ Chilliness of specific body areas: _____
- ☐ Morning hot flashes
- ☐ Afternoon hot flashes
- ☐ Alternating fever & chills

Sweating

- ☐ Night sweats
- ☐ Daytime sweats
- ☐ Frequent sweating
- ☐ Profuse sweating
- ☐ Scant sweating
- ☐ Sweating of specific body areas: _____
- ☐ Sweat for no reason

Energy

On a scale of 0-10 I would rate my current energy level at _____

- ☐ Plenty of energy
- ☐ Frequently tired
- ☐ Take daily naps
- ☐ Slow starter in the AM
- ☐ Rely on caffeine to get me started in the AM
- ☐ "Night owl"
- ☐ Energy level drops after I eat
- ☐ Energy levels are inconsistent

Sleep

I sleep _____ hours per night

- ☐ Difficulty falling asleep
- ☐ Difficulty staying asleep
- ☐ Need more sleep
- ☐ Restless sleep
- ☐ Never feel rested
- ☐ Light sleep
- ☐ Pain prevents me from sleeping
- ☐ Profuse dreaming
- ☐ Frequent nightmares
- ☐ Sleep walking
- ☐ Dream disturbed sleep
- ☐ Waking too early
- ☐ Excessive sleep

Predominant Moods

- ☐ Depressed
- ☐ Sad
- ☐ Tearful
- ☐ Irritable
- ☐ Easily irritated
- ☐ Angry
- ☐ Easily angered
- ☐ Anxious
- ☐ Worried
- ☐ Stressed
- ☐ Fearful
- ☐ Manic / agitated
- ☐ Grieving
- ☐ Other _____

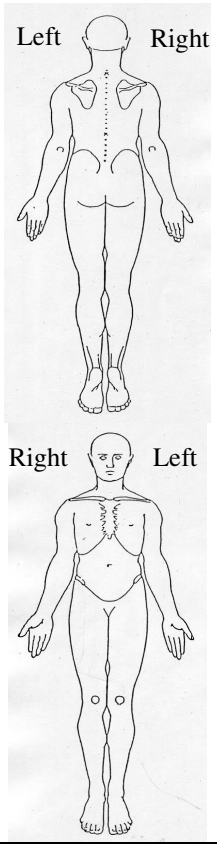
Stress

- ☐ High stress levels
- ☐ Low stress levels
- ☐ Work stress
- ☐ Relationship stress
- ☐ No real outlet for stress
- ☐ Anxiety / panic attacks
- ☐ Lack of social support network

Pain

- ☐ Rarely experience pain
- ☐ Minor aches & pains
- ☐ Moderate to strong pain
- ☐ Unbearable pain & nothing helps it
- ☐ Pain improves with rest
- ☐ Pain improves with movement & stretching
- ☐ Pain worse at night
- ☐ Pain worse in morning
- ☐ Heat helps pain
- ☐ Cold helps pain
- ☐ Pain is constant
- ☐ Pain comes and goes
- ☐ Sharp, stabbing pain
- ☐ Dull achy pain
- ☐ Massage / pressure helps my pain
- ☐ Massage / pressure makes my pain worse
- ☐ Pain interferes with my daily activities

On the diagram below, shade in the areas where you feel pain. Put an X on the area that hurts the most



Lung / Large Intestine

- ☐ History of grief or loss that feels unresolved
- ☐ Change in skin texture
- ☐ Perspire with little or no exertion
- ☐ Acne, pimples or other skin problems
- ☐ Prone to respiratory ailments
- ☐ Frequent colds & flu
- ☐ Tendency towards constipation
- ☐ Sore throat
- ☐ Hoarse voice / weak voice
- ☐ Cough
- ☐ Wheezing
- ☐ Shortness of breath

Kidney / Urinary Bladder

- ☐ Weak & sore lower back
- ☐ Knee pain / weakness
- ☐ Ringing in the ears
- ☐ Poor hearing
- ☐ Feel afraid / fearful
- ☐ Changes in libido
- ☐ Erectile dysfunction
- ☐ Premature ejaculation
- ☐ Hair loss
- ☐ Premature gray hair
- ☐ Frequent urination
- ☐ Urinary incontinence
- ☐ History of kidney stones
- ☐ Awaken at night to urinate
- ☐ Urinary urgency
- ☐ Pain with urination

Spleen / Stomach

Please circle one: I would describe my typical appetite as being

- poor - fair
- good -excellent
- excessive
- inconsistent

- ☐ Bruise easily
- ☐ Crave sweets
- ☐ Feel bloated after meals
- ☐ Feel tired after meals
- ☐ Muscle weakness
- ☐ Tend to have loose stools
- ☐ Weight gain past 6 months: amount _____
- ☐ Hemorrhoids
- ☐ Frequently worried
- ☐ Acid reflux / GERD
- ☐ Weight loss past 6 months: amount _____
- ☐ Unusual taste in mouth
- ☐ Bad breath
- ☐ Mouth sores
- ☐ Cracked dry lips
- ☐ Painful, swollen, bleeding gums
- ☐ Excessive hunger
- ☐ Nausea
- ☐ Vomiting
- ☐ Frequent indigestion
- ☐ Hiccups / belching
- ☐ Alternating diarrhea & constipation
- ☐ Frequent nosebleeds
- ☐ Abdominal distention
- ☐ Sinus congestion

Heart / Small Intestine

- ☐ Heart palpitations
- ☐ Insomnia
- ☐ Difficulty speaking
- ☐ Forgetfulness
- ☐ Pale complexion
- ☐ Numbness in the limbs
- ☐ Dizziness
- ☐ Short of breath with exertion / activity
- ☐ Recently experienced a “broken heart”
- ☐ Chest pain
- ☐ Chest fullness
- ☐ Poor memory
- ☐ Easily startled
- ☐ Mental restlessness
- ☐ Tongue ulcers

Liver / Gallbladder

- ☐ Blurry vision
- ☐ Floaters or spots in visual field
- ☐ Dry eyes
- ☐ Itchy eyes
- ☐ Red eyes
- ☐ Stress headaches
- ☐ Headaches that affect your eyes and/or temples
- ☐ Headaches that occur at the base of the skull
- ☐ Frustrated
- ☐ Lump in the throat sensation
- ☐ Feel full or distended beneath my ribcage
- ☐ Teeth grinding
- ☐ Dry brittle nails
- ☐ Tight tendons or inflexible muscles
- ☐ Difficulty making decisions
- ☐ Timid personality
- ☐ History of gallstones
- ☐ Mood swings
- ☐ Frequent sighing

Please list any comments, concerns, questions or other issues that you would like to discuss.

Thank you. Enjoy your treatment!