energy balance health

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Health History Questionnaire

Date:

Please help me provide you with a complete evaluation by taking the time to fill out this questionnaire carefully. All of your answers will be held **absolutely** confidential. If you have questions, please ask. If there is anything you wish to bring to my attention which is not asked on this form, please note it in the Comments section. Thank you!

Name: Email:

Phone: Cell: Work

Street:

City:

State: Zip:

Age: DOB: Height: Weight:

Place of Birth: Marital Status:

Family Physician

In Emergency notify:

Referred by:

Have you ever been treated by acupuncture or Oriental medicine before?

Main problem(s) you would like me to help you with:

How long ago did this problem begin (be specific)?

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

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

What kind of treatments have you tried?

Past medical history (please include date)**:**

Significant Illnesses:

Cancer	Diabetes	Hepatitis	High Bood Pressure
Heart Disease	Rheumatic Fever	Thyroid Disease	Seizures
Venereal Disease	Other		

Surgeries:

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

Birth History (prolonged labor, forceps delivery, etc.:

Allergies (drugs, chemicals, foods):

Family Medical History: Diabetes Cancer High Blood Pressure
Heart Disease Stroke Seizures Asthma Allergies

Medicines taken within the last two months (vitamins, drugs, herbs, etc.):

Occupation: Occupational stress (chemical, physical, psychological, etc.):

Do you have a regular exercise program? Please describe:

Have you ever been on a restricted diet? What kind:
Please describe your average diet:
Morning Afternoon Evening

How many packs of cigarettes do you smoke a day?
How much coffee, tea, or cola do you drink per week?
How much alcohol do you drink per week?
Please describe any use of drugs for non-medical purposes:

Describe painful or distressed areas:

Please check if you had (in the last three month):

GENERAL

☐ Poor Appetite	☐ Poor Sleeping	☐ Fatigue
☐ Fevers	☐ Chill	☐ Night sweats
☐ Sweat easily	☐ Tremors	☐ Cravings
☐ Localized weakness	☐ Poor balance	☐ Change in appetite
☐ Bleed or bruise easily	☐ Weight loss	☐ Weight gain
☐ Peculiar tastes or smells	☐ Strong thirst (cold or hot drinks)	☐ Sudden energy drop (What time of day)?

SKIN AND HAIR

- ☐ Rashes
- ☐ Ulcerations
- ☐ Hives
- ☐ Itching
- ☐ Eczema
- ☐ Pimples
- ☐ Dandruff
- ☐ Loss of Hair
- ☐ Recent moles
- ☐ Change in hair or skin texture

Any other hair or skin problems?

HEAD, EYES, EARS, NOSE, AND THROAT

- ☐ Dizziness
- ☐ Concussions
- ☐ Migraines
- ☐ Glasses
- ☐ Eye strain
- ☐ Eye pain
- ☐ Poor vision
- ☐ Night blindness
- ☐ Color blindness
- ☐ Cataracts
- ☐ Blurry vision
- ☐ Earaches
- ☐ Ringing in ears
- ☐ Poor hearing
- ☐ Spots in front of eyes
- ☐ Sinus problems
- ☐ Nose bleeds
- ☐ Recurrent sore throats
- ☐ Grinding teeth
- ☐ Facial pain
- ☐ Sores on lips or tongue
- ☐ Teeth problems
- ☐ Jaw clicks
- ☐ Headaches (where/when)

Any other head or neck problems?

CARDIOVASCULAR

- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Chest Pain
- ☐ Irregular heartbeat
- ☐ Dizziness
- ☐ Fainting
- ☐ Cold hands and feet
- ☐ Swelling of hands
- ☐ Swelling of feet
- ☐ Blood clots
- ☐ Phlebitis
- ☐ Difficulty in breathing

Any other heart or blood vessel problems?

RESPIRATORY

- ☐ Cough
- ☐ Coughing blood
- ☐ Asthma
- ☐ Bronchitis
- ☐ Pneumonia
- ☐ Pain with a deep breath
- ☐ Difficulty in breathing lying down
- ☐ Production of phlegm - What color?

Any other lung problems?

GASTROINTESTINAL

- ☐ Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Gas
- ☐ Belching
- ☐ Black stools
- ☐ Blood in stools
- ☐ Indigestion
- ☐ Bad Breath
- ☐ Rectal pain
- ☐ Hemorrhoids
- ☐ Abdominal pain or cramps
- ☐ Chronic laxative use
- ☐

Any other problems with your stomach or intestines?

GENITO-URINARY

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

Do you wake up to urinate? How often? ____________________

Any particular color to your urine? ____________________

Any other problems with your urinary or genital system?

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REPRODUCTIVE AND GYNECOLOGIC

_____ Number of pregnancies
_____ Number of births
_____ Premature births

_____ Misscariages
_____ Abortions
_____ Age at first menses

_____ Period between menses
_____ Duration
_____ First date of last menses

- ☐ Unusual character (heavy or light)
- ☐ Irregular periods
- ☐ Painful periods
- ☐ Vaginal discharge
- ☐ Clots
- ☐ Last PAP
- ☐ Changes in body/psyche prior to menstruation
- ☐ Vaginal sores
- ☐ Breast lumps
- ☐ Menopause (Age:_____)

Do you practice birth control? ____________________

What type of birth control and for how long?

____

MUSCULOSKELETAL

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

Any other joint or bone problems?

____

NEUROPSYCHOLOGICAL

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

Have you ever been treated for emotional problems?

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Have you ever considered or attempted suicide?

____

Any other neurological or psychological problems?

____

COMMENTS

Please tell me about any other problems you would like to discuss:

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