

HEALTH HISTORY QUESTIONNAIRE

Please help us 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 our attention which is not asked on this form, please note it in the "Comments" section. Thank you.

Name _____ Date _____

Street _____ City _____ State/Zip _____

Home Phone _____ Work Phone _____ eMail _____

Age _____ Date of Birth _____ Male _____ Female _____ Height _____ Weight _____

Race: American Indian or Alaska native Asian Black or African American
 Native Hawaiian or Other Pacific Islander White

Ethnicity: Hispanic or Latino Not Hispanic or Latino

Marital Status: Married Never Married Widowed Divorced or Separated

Education: Grammar School High School College Masters Doctorate

Occupation: _____ Retired: _____ Disabled: _____ Unemployed: _____

Family Physician: _____ Referred by: _____

Emergency Contact: _____ Emergency Contact Relation to you: _____

Emergency Contact telephone: _____

Have you ever been treated by acupuncture or Oriental medicine before? Yes No

Main Problem you would like us to help you with: _____

How long ago did this problem begin? Please be specific: _____

Have you been given a diagnosis for this problem? If so, what diagnosis and by whom?

What other kinds of treatment have you tried? Western Medicine Acupuncture
 Herbs Massage Physical Therapy Chiropractor Reiki Homeopathy
 Other: _____

How confident are you that Acupuncture and Chinese herbal medicine will be able to resolve the symptoms of your main complaint?

Not confident Slightly confident Moderately confident Confident Very confident

Secondary Complaints you would like us to help you with: _____

Past Personal Medical History of Significant Illnesses: Asthma Allergies Diabetes

Cancer Stroke Heart disease High Blood Pressure Seizures Hepatitis

Rheumatic Fever Thyroid disease Venereal disease Other: _____

Hospitalizations/Surgeries (including dates): _____

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

Allergies (drugs, chemicals, metals, foods): _____

Family Medical History: (check all that are applicable) Asthma Allergies Diabetes

Cancer Stroke Heart disease High Blood Pressure Seizures Thyroid

Hepatitis Rheumatic Fever Thyroid disease Venereal disease Other: _____

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

Are there any areas of your life that you find stressful? Please describe: _____

Do you have a regular exercise program? No Yes If yes, please describe: _____

Do you follow any type of special diet (e.g. vegetarian, vegan, medical related, or other)?

No Yes If Yes, what type of diet? _____

Describe your average daily diet:

Morning: _____

Afternoon: _____

Evening: _____

Do you smoke? No Yes If Yes, how many cigarettes or cigars per day? _____

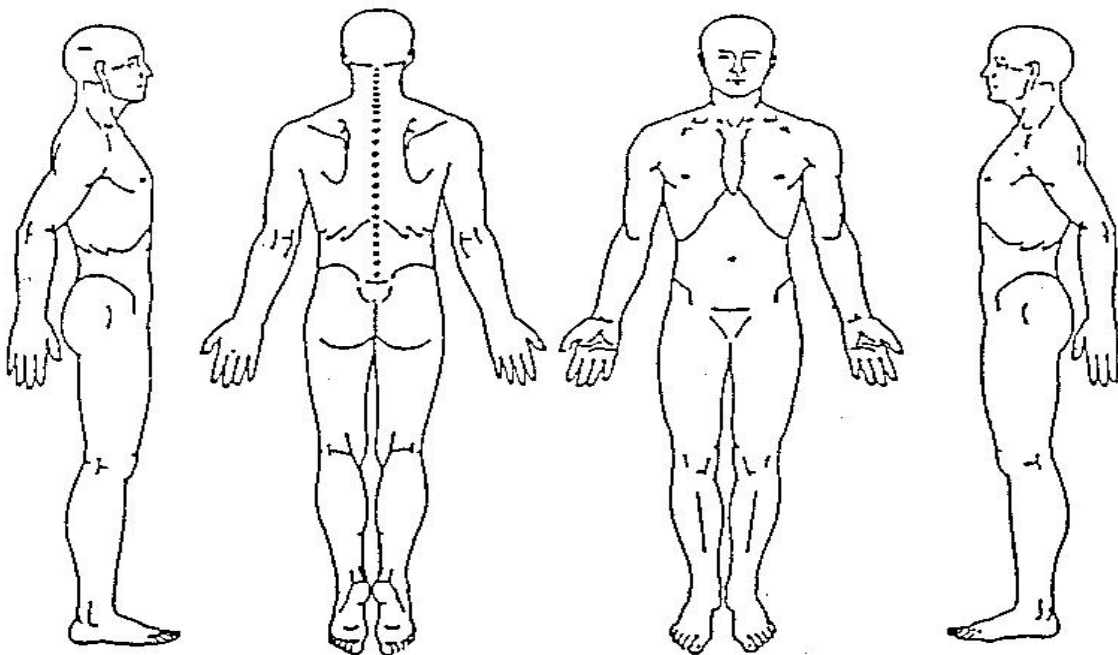
How many cups of caffeinated coffee, tea, or cola do you drink per week? _____

How many 8 oz. glasses of water do you drink per day? _____

How many alcoholic beverages do you drink per week? _____

Please describe any use of drugs for non-medical purposes: _____

Please indicate any painful or distressed body areas by circling the particular area:



Please check if you have had any of the following, particularly if in the last three months:

GENERAL:

- Fevers
- Chills
- Fatigue
- Sweat easily
- Poor sleeping
- Night sweats
- Weight loss
- Cravings
- Weight gain
- Change in appetite
- Strong thirst for: Hot drinks Cold drinks
- Sudden energy drop, if so what time of day? _____
- Bleed or bruise easily
- Peculiar tastes or smells

SKIN & HAIR:

- Rashes
- Ulcerations
- Hives
- Itching
- Eczema
- Pimples
- Dandruff
- Loss of hair
- Recent moles
- Psoriasis
- Dermatitis
- Acne
- Change in hair or skin texture
- Any other skin or hair problems? _____

HEAD, EYES, EARS, NOSE & THROAT:

- Dizziness
- Concussions
- Migraines
- Glasses
- Eye strain
- Eye pain
- Poor vision
- Night blindness
- Color blindness
- Cataracts
- Blurry vision
- Earaches
- Ringing in ears
- Spots in front of eyes
- Poor hearing
- Sinus problems
- Nose bleeds
- Recurrent sore throats
- Grinding teeth
- Clenching jaw
- Facial pain
- Sores on lips or tongue
- Teeth problems
- Jaw clicks
- Headaches, where and when? _____
- Any other head or neck problems? _____

CARDIOVASCULAR:

- High blood pressure
- Low blood pressure
- Chest pain
- Fainting
- Irregular heart beat
- Difficulty in breathing
- Blood clots
- Phlebitis
- Cold hands or feet
- Swelling of hands
- Swelling of feet
- Varicose or spider veins
- Palpitations
- Palpitations at rest
- Any other heart or blood vessel problems? _____

RESPIRATORY:

- Cough
- Coughing blood
- Asthma
- Bronchitis
- Pneumonia
- Pain with deep breath
- Chest tightness
- Difficulty breathing when lying down
- Phlegm production, what color? _____

GASTROINTESTINAL:

- Nausea
- Vomiting
- Diarrhea
- Constipation
- Gas
- Belching
- Black stools
- Blood in stools
- Indigestion
- Bad breath
- Rectal pain
- Hemorrhoids
- Bleeding gums
- Food stagnation
- Bloating/edema
- Acid reflux/GERD
- Hernia
- Excessive appetite
- Poor appetite
- IBS/Crohn's disease
- Colitis
- Slow digestion
- Abdominal pain/cramps
- Chronic laxative use
- Loose stools, more than 2 per day
- Any other problem with Stomach or intestines? _____

GENITO-URINARY:

- Frequent urination
- Blood in urine
- Pain upon urination
- Urgency to urinate
- Unable to hold urine
- Kidney stones
- Decrease in flow
- Impotency
- Sores on genitals
- Any particular color to your urine? _____

- Do you wake up at night to urinate? If yes, how many times a night? _____
- Any other problems with your genital or urinary systems? _____

REPRODUCTIVE & GYNECOLOGIC:

- Are you pregnant? Yes No
 Is it possible that you are pregnant? Yes No
 Number of pregnancies: _____ Live Births: _____ Miscarriages: _____
 Abortions: _____ Premature births: _____
 Age at first menses: _____ Time period between menses: _____
 Duration of menses: _____ Last PAP: _____
- Irregular periods Painful periods Clots Breast lumps
 - Vaginal sores Vaginal discharge Vaginal dryness Endometriosis
 - Uterine fibroids Polycystic Ovarian disease Fibrocystic breast tissue
 - Unusual character of blood (heavy, scanty) _____
- Do you practice birth control? Yes No If yes, what type? _____ How long? _____

MUSCULOSKELETAL:

- Neck pain Rotator cuff Knee pain Foot/ankle pain
- Muscle pain Muscle spasm Muscle weakness Shoulder pain
- Hip pain Sciatica Bursitis Hand/wrist pain
- Carpal tunnel Sprains/strains Tendonitis
- Back pain: Low _____ Middle _____ Upper _____
- Soreness/weakness of lower body (back, hip, knee, ankle, foot)

NEUROLOGICAL & PSYCHOLOGICAL:

- Seizures Dizziness Loss of balance Areas of numbness
 - Poor memory Concussion Poor coordination Bad temper
 - Anxiety Depression Easily susceptible to stress
 - Nervousness ADD/ADHD Manic depression
- Have you ever been treated for emotional problems? Yes No
 Have you ever considered or attempted suicide? Yes No
 Any other neurological or psychological problems? _____

COMMENTS: *Please tell us briefly of any other problems you would like to discuss.*

Please complete the reverse side...a form that will help NESAs gather information about the different types of complaints treated at the NESAs Clinic. At the end of the semester, you will be asked to complete a similar form that will measure the outcome of your treatments. Thank you.

Your Current Health Status

Initial Visit

NEW PATIENTS: If you are a new patient, please complete this form before your first treatment. If you have any questions about how to complete the form, you may ask the front desk staff for help. Please return the completed form to the front desk when you are done.

Your Name:
(PLEASE PRINT)

Today's Date:
(PLEASE PRINT)

INSTRUCTIONS: Choose one or two symptoms (physical or mental) which bother you the most. Write them on the lines. Now consider how bad each symptom is, over the last week, and score it by circling your chosen number.

SYMPTOM 1:

(PLEASE PRINT)

0

As good as it could be

1

2

3

4

5

6

As bad as it could be

SYMPTOM 2:

(PLEASE PRINT)

0

As good as it could be

1

2

3

4

5

6

As bad as it could be

Now choose one activity (physical, social, or mental) that is important to you, and that your problem makes difficult or prevents you doing. Score how bad it has been in the last week.

ACTIVITY:

(PLEASE PRINT)

0

As good as it could be

1

2

3

4

5

6

As bad as it could be

Lastly, how would you rate your general feeling of WELLBEING during the last week?

0

As good as it could be

1

2

3

4

5

6

As bad as it could be

How long have you had Symptom 1, either all the time or on and off? (Please circle):

0 - 4 weeks

4 - 12 weeks

3 months - 1 year

1 - 5 years

over 5 years

Are you taking any medication for this problem? (Please circle):

YES

NO

If YES:

1. Please write in the name of the medication, and how much you take a day or a week:

2. Is cutting down this medication

(Please circle):

Not Important

A bit Important

Very Important

Not Applicable

If NO:

Is avoiding medication for this problem

(Please circle):

Not Important

A bit Important

Very Important

Not Applicable

THIS BOX FOR OFFICE USE ONLY

CHART-No

THIS BOX FOR OFFICE USE ONLY

DE-by-on: