



### Health History Questionnaire

Please take the time to fill out this questionnaire completely and carefully to help us provide you with a complete health evaluation. We realize that some questions may seem irrelevant to your main problem, but they are significant in helping us to make an accurate diagnosis and formulate an appropriate treatment plan. All of your answers will be held absolutely confidential. If you have any 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.

If you need more space, please use the other side of these sheets.

Patient Name \_\_\_\_\_ Date \_\_\_\_\_

Street \_\_\_\_\_ City \_\_\_\_\_ State/Zip \_\_\_\_\_

Age \_\_\_\_\_ Date of Birth \_\_\_\_\_ Male \_\_\_\_\_ Female \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_

Email \_\_\_\_\_ Phone: Home \_\_\_\_\_ Cell \_\_\_\_\_  
*(Please circle which number you would prefer we contact you)*

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

Marital Status:  Married  Never Married  Widowed  Divorced or Separated

Education:  Grammar School  High School  College  Masters  Doctorate

Occupation (or most recent job held): \_\_\_\_\_  Retired  Disabled  Unemployed

Primary Physician \_\_\_\_\_ Physician's Phone \_\_\_\_\_ Referred by \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Emergency Contact Relation to you: \_\_\_\_\_

Emergency Contact telephone: \_\_\_\_\_

Where did you hear about us/how did you find us: \_\_\_\_\_

Have you received acupuncture and/or Chinese herbal medicine before? Yes / No Your dominate hand? Left / Right

What is your Chief Complaint (CC) for today? *(Symptoms, location, Quality, Mechanism of Injury, Timing, Diagnosis, Duration, etc.)*

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

Please answer the questions below if applicable:

- When did the chief complaint first begin? Please be specific: \_\_\_\_\_
- Have you been given a diagnosis for the chief complaint? If so, what diagnosis and by whom \_\_\_\_\_
- How long and how often does this bother you? \_\_\_\_\_
- Is the chief complaint related to trauma, accident, work, or others? Please be specific: \_\_\_\_\_
- Have you been seen any other professions for the same chief complaint? Please be specific: \_\_\_\_\_
- Severity of the problem on a scale of 0-10 (0 = best; 10 = worst): At its best: \_\_\_/10; At its worst: \_\_\_/10; Average: \_\_\_/10; Right now: \_\_\_/10

➤ If there is pain involved, what is the pain level on a scale of 0-10 (0 = best; 10 = worst):

At its best: \_\_\_/10; At its worst: \_\_\_/10; Average: \_\_\_/10; Right now: \_\_\_/10

➤ If there is pain involved, what is the quality of the pain? (Circle all that apply)

Dull Achy Burning Sharp Stabbing Cold Numb Tingling Throbbing Other \_\_\_\_\_

➤ What makes the chief complaint feel better? (Circle all that apply)

Heat Cold Damp weather Wind Rest Work Movement Sitting Lying Massage/Pressure Stress Other \_\_\_\_\_

➤ What makes the chief complaint feel worse? (Circle all that apply)

Heat Cold Damp weather Wind Rest Work Movement Sitting Lying Massage/Pressure Stress Other \_\_\_\_\_

➤ To what extent does the chief complaint interfere with your daily activities (work, sleep, sex, etc.)? \_\_\_\_\_

➤ What kinds of treatment have you tried?  Western Medicine  Acupuncture  Herbs  Massage  Physical Therapy

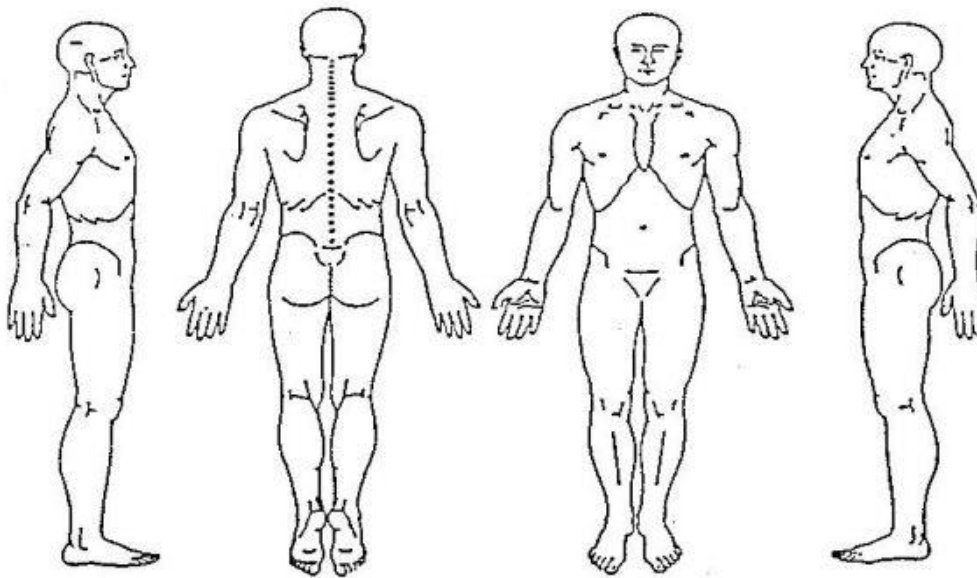
Chiropractor  Reiki  Homeopathy  Other: \_\_\_\_\_

➤ How confident are you that you can resolve the symptoms of your main complaint with acupuncture and/or Chinese herbal medicine?

Not confident  Slightly confident  Moderately confident  Confident  Very confident

➤ Please indicate the location of the chief complaint, pain, or the area affect by the chief complaint by circling the particular area:

CONFI



ENTER

Secondary Complaints (related or unrelated to the chief complaint) you would like us to help you with:

(1) \_\_\_\_\_

(2) \_\_\_\_\_

(3) \_\_\_\_\_

More \_\_\_\_\_

Personal Health Information

**Patient Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Hospitalizations/Surgeries (including dates): \_\_\_\_\_

Significant Trauma (physical or emotional; auto accidents, falls, etc.): \_\_\_\_\_

Allergies (medications, environmental, food, drugs, etc.): \_\_\_\_\_

Past Medical History (Please check the box):

<input type="checkbox"/> Diabetes	<input type="checkbox"/> Osteoporosis	<input type="checkbox"/> Blood Clots	<input type="checkbox"/>
<input type="checkbox"/> Chest Pain / Angina	<input type="checkbox"/> Asthma/COPD	<input type="checkbox"/> Peripheral Vascular Disease	<input type="checkbox"/>
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Stroke/CVA/TIA	<input type="checkbox"/> Tuberculosis	<input type="checkbox"/>
<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Seizures	<input type="checkbox"/> Depression	<input type="checkbox"/>
<input type="checkbox"/> Heart Attack	<input type="checkbox"/> HIV/AIDS	<input type="checkbox"/> Congestive Heart Failure	<input type="checkbox"/>
<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Thyroid Disease	<input type="checkbox"/>
<input type="checkbox"/> Pacemaker	<input type="checkbox"/> Stomach Ulcer	<input type="checkbox"/> Other (Please list below):	<input type="checkbox"/>
<input type="checkbox"/> Headaches	<input type="checkbox"/> Liver Disease		
<input type="checkbox"/> Kidney Stones	<input type="checkbox"/> Heart Palpitations		
<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Arthritis		
<input type="checkbox"/> Cancer	<input type="checkbox"/> Heart Surgery		

Current Medications:

Name of the medication	Reason for taking

ROS	-	Please check all CURRENT positive findings
Constitutional		Weight loss <input type="checkbox"/> Fevers <input type="checkbox"/> Chills <input type="checkbox"/> Poor appetite <input type="checkbox"/> Fatigue <input type="checkbox"/> Weight gain <input type="checkbox"/> Insomnia <input type="checkbox"/> Night sweats <input type="checkbox"/>
Eyes		Blurry vision <input type="checkbox"/> Eye pain <input type="checkbox"/> Eye discharge <input type="checkbox"/> Eye redness <input type="checkbox"/> Decrease in vision <input type="checkbox"/> Dry eyes <input type="checkbox"/> Double vision <input type="checkbox"/>
ENT		Sore throat <input type="checkbox"/> Hoarseness <input type="checkbox"/> Ear pain <input type="checkbox"/> Hearing loss <input type="checkbox"/> Ear discharge <input type="checkbox"/> Nose bleeds <input type="checkbox"/> Tinnitus <input type="checkbox"/> Sinus problems <input type="checkbox"/>
Cardiovascular		Chest pain <input type="checkbox"/> Palpitations <input type="checkbox"/> Rapid heart rate <input type="checkbox"/> Heart murmur <input type="checkbox"/> Poor circulation <input type="checkbox"/> Swelling in the legs or feet <input type="checkbox"/>
Respiratory		Shortness of breath <input type="checkbox"/> Chronic cough <input type="checkbox"/> Coughing up blood <input type="checkbox"/> History of Tuberculosis <input type="checkbox"/> Excess sputum production <input type="checkbox"/>
Gastrointestinal		Nausea <input type="checkbox"/> Vomiting <input type="checkbox"/> Diarrhea <input type="checkbox"/> Constipation <input type="checkbox"/> Blood in the stool <input type="checkbox"/> Frequent heartburn <input type="checkbox"/> Trouble swallowing <input type="checkbox"/>
Genitourinary		Increased urinary frequency <input type="checkbox"/> Blood in the urine <input type="checkbox"/> Incontinence <input type="checkbox"/> Painful urination <input type="checkbox"/> Urinary retention <input type="checkbox"/> Frequent UTIs <input type="checkbox"/>
Skin		Rash <input type="checkbox"/> Hives <input type="checkbox"/> Hair loss <input type="checkbox"/> Skin sores or ulcers <input type="checkbox"/> Itching <input type="checkbox"/> Skin thickening <input type="checkbox"/> Nail changes <input type="checkbox"/> Mole changes <input type="checkbox"/>
Musculoskeletal		Joint pain <input type="checkbox"/> Muscle aches <input type="checkbox"/> Frequent leg cramps <input type="checkbox"/> Muscle weakness <input type="checkbox"/> Bone pain <input type="checkbox"/> Joint swelling <input type="checkbox"/> Back pain <input type="checkbox"/>
Psychiatric		Anxiety <input type="checkbox"/> Depression <input type="checkbox"/> Alcohol or drug dependence <input type="checkbox"/> Suicidal thoughts <input type="checkbox"/> Panic attacks <input type="checkbox"/> Use of anti-depressants <input type="checkbox"/>
Endocrine		Goiter <input type="checkbox"/> Heat intolerance <input type="checkbox"/> Cold intolerance <input type="checkbox"/> Increased thirst <input type="checkbox"/> Change in skin pigment <input type="checkbox"/> Excess sweating <input type="checkbox"/>
Neurological		Seizures <input type="checkbox"/> Tremors <input type="checkbox"/> Migraines <input type="checkbox"/> Numbness <input type="checkbox"/> Dizziness/Vertigo <input type="checkbox"/> Loss of balance <input type="checkbox"/> Slurred speech <input type="checkbox"/> Stroke <input type="checkbox"/>
Hem/Lymphatic		Low blood count <input type="checkbox"/> Easy bruising <input type="checkbox"/> Swollen lymph nodes <input type="checkbox"/> Transfusions <input type="checkbox"/> Prolonged bleeding <input type="checkbox"/> Blood clots <input type="checkbox"/>
Allergic/Immun		Allergic reactions <input type="checkbox"/> Hay fever <input type="checkbox"/> Frequent infections <input type="checkbox"/> Hepatitis <input type="checkbox"/> HIV positive <input type="checkbox"/> Positive tuberculin skin test (PPD) <input type="checkbox"/>

Non-Smoker (never smoked)  Ex=Smoker  Current Smoker  How many packs per day? \_\_\_\_\_

Alcohol consumption: Never  Occasional  Frequent

Family History: (Please list any known medical problems):

Father: \_\_\_\_\_ Mother: \_\_\_\_\_

Siblings: \_\_\_\_\_

Your Children: \_\_\_\_\_

Additional Information: Use this space to provide any additional information which may be important to your health care.

Signature of Reviewing Examminer \_\_\_\_\_ Date \_\_\_\_\_ Signature of Patient \_\_\_\_\_ Date \_\_\_\_\_

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

Do you have a regular exercise program? Days per week \_\_\_\_\_ Length of workout \_\_\_\_\_ Type of Activity \_\_\_\_\_

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

**Gynecological/Reproductive (Women Only)**

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 test: \_\_\_\_\_

Date of last menses: \_\_\_\_\_ Do you practice birth control? \_\_\_\_\_ What type? \_\_\_\_\_ How long? \_\_\_\_\_

<input type="checkbox"/> Irregular periods	<input type="checkbox"/> Painful periods	<input type="checkbox"/> Clot
<input type="checkbox"/> Difficult/Painful intercourse	<input type="checkbox"/> Ovarian cysts	<input type="checkbox"/> Endometriosis
<input type="checkbox"/> Vaginal dryness/itching	<input type="checkbox"/> Vaginal sores	<input type="checkbox"/> Vaginal discharge (color/amount/odor _____)
<input type="checkbox"/> Uterine Fibroids	<input type="checkbox"/> Polycystic Ovarian Syndrome	<input type="checkbox"/> Fibrocystic breast tissue
<input type="checkbox"/> PMS	<input type="checkbox"/> Breast lumps	<input type="checkbox"/> Infertility
<input type="checkbox"/> Sexually transmitted disease	<input type="checkbox"/> Unusual character of blood (heavy, scanty) _____	

Please fill in the following menstrual chart:

	Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7
<b>Color</b> (normal, bright red, pale, brown, rust, dark, purple, other)							
<b>Amount of flow</b> (normal, heavy, light)							
<b>Pain/cramps</b> (location, dull, sharp, other)							
<b>Clots</b> (describe size: large, small, black, purple, red, other)							
<b>Vomiting/nauseas</b> (check if yes)							
<b>PMS</b> (what symptoms, duration of symptoms)							
<b>Other</b>							

Have you ever been treated for emotional problems?  Yes  No

Have you ever considered or attempted suicide?  Yes  No

Have you ever been treated for substance abuse?  Yes  No

**Comments:** (Please tell us briefly of any other problems you would like to discuss)

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

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform Tai Chi Acupuncture & Wellness Center, LLC of any changes in my medical status. I also authorize the healthcare staff to perform the necessary health care services I may need.

Patient Signature: **X** \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Reviewing Examiner: **X** \_\_\_\_\_ Date: \_\_\_\_\_