Health History Questionnaire

Note: information provided on this form is confidential
Important: complete this packet as thoroughly and accurate as possible to assist you properly in your healing process

I. General Patient Information

Date: ____/____/____
Last name:_____ First name:_____
Home Phone:_____ Cell Phone:_____ Email:_____
Work Phone:_____ Occupation:_____

Address: _____
City:_____ State:_____ Zip:_____

Date of Birth:____/____/____ Age:_____ Guardian:_____
Single:___ Married:___ Divorced:___ Widowed:___ Other:_____

Emergency Contact Person:_____ Relationship:_____
Telephone (home/work/cell)(circle one):_____

Primary Physician:_____ Telephone:(___)_____
OB/GYN:_____ Telephone: (___)_____
Reproductive Endocrinologist:_____ Telephone:(___)_____
Referred by:_____
Is this your first acupuncture treatment? □ yes □ no Date of first treatment:_____
How was your first experience/How did you feel? _____

II. Insurance Information

Insured's Name:_____ DOB: ___/___/___ SSN:_____
Address:(□ check is same as above) _____
City:_____ State:_____ Zip:_____ Phone:(___)_____
Patient's relationship to insured:_____
Primary Insurance Company: _____
Address:_____ City:_____
State:_____ Zip:_____ Customer Service Number:(____)_____
Identificaton Number:_____ Group Number:_____

I hereby give my consent for treatment by Cynthia Lai, L.Ac. Dipl. O.M. I accept full financial responsibility for all medical services performed on my behalf.

_____ _____
Patient Signature **Parent/Guardian Signature**

III. Patient Profile

What is your chief complaint?_____
Pain level: □ minimal □ moderate □ severe
Do you have a western medical diagnosis?_____
How long have you had this condition?_____ Have you had this condition before?
□ Yes □ No Does anything limit you from care? □ yes □ no If yes, please explain: _____
_____

Medications/Supplements/Dosage	Reason/Objective	Date Started
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Allergies: (including food and medication, etc.)_____
Do you have a regular exercise program? Please describe. _____
_____

Please Describe your average daily diet:
Breakfast Lunch Dinner
_____
_____
_____

Have you ever been on a restricted diet? Please describe. _____
_____
How many packets of cigarettes do you smoke a day?_____
How much coffee, tea, and/or cola do you drink per day?_____
How much alcohol do you drink per week? What type?_____
Please describe any use of drugs for non-medical purposes:
_____
Do you have a stressful occupation? YES NO
If yes, please explain:_____

IV. Past Medical History

___Mumps	___Fibromyalgia	___Scarlet Fever
___Measles	___Heart Disease	___Seasonal Allergies
___Chicken Pox	___Pacemaker	___STDs
___AIDS/HIV	___Rheumatic Fever	___Seizures
___Alcoholism	___Hepatitis A/B/C	___Sinus Infections
___Drug Addictions	___Herpes	___Tuberculosis
___Depression	___Asthma	___Joint Replacements
___Surgeries	___Emphysema	___Polio
___Birth Trauma	___Lyme's Disease	___Depression
___Cancer	___Lymph Nodes removed	___Psychological Disorders
___Diabetes	___Multiple Sclerosis	___Other:_____

V. Family Medical History: (Please check any and all condition(s))

Illness:	Father	Mother	Siblings	Grandparents	Aunts/Uncles
Cancer					
Diabetes					
High Blood Pressure					
Heart Disease					
Allergies					
Drug Abuse					
Alcoholism					
Mental Illness					
Seizures					
Strokes					
Other					

VI. General Health Information

Major Health Complaints and/or Symptoms:

1. _____
2. _____
3. _____

Please explain how these conditions affect your daily life and daily activities:

_____
_____

Describe your symptoms when they are at their worst:

_____
_____

What makes your symptoms better:

_____
_____

How is your sleep quality? _____
How many hours of sleep do you get per night? _____
I have difficulty with: (Circle all that apply)

Falling asleep Staying asleep Dream-disturbed sleep
Waking up and not being able to fall asleep again

How do you feel emotionally? _____
_____

Do you have: (Circle all that apply)

Panic attacks Depression Anxiety Anger
Poor memory Poor concentration Bad temper Irritability

Are you in a relationship now? YES NO
How do you feel about your relationship? _____
How do you hold stress? _____
How do you relax? _____
How do you feel about your work? _____

VII. Gynecological History

Age of first period: _____
Last menstrual period date:_____ Cycle day today: _____
Are your periods regular? _____
Number of days between periods: _____ Days of bleeding: _____
Amount of bleeding: (circle one) LIGHT MEDIUM HEAVY
Color of blood: BROWN BRIGHT RED DARK RED PURPLE BLACK PINK ALL
LIGHT PALE
Consistency: THICK WATERY NORMAL
Any clots? YES NO
Do you spot in between periods? YES NO
Any cramping? YES NO
Pain level: MILD MODERATE SEVERE
Type of pain: Sharp/stabbing Dull/achy
Does pain start before period? YES NO
Does pain start at onset of period? YES NO
Does pain start at the end or after period? YES NO
Does pain persist more than 48 hours? YES NO
Please list all PMS symptoms: _____
_____

Any vaginal dryness? YES NO
Any vaginal discharge? YES NO If so, what color and consistency? _____
Have you ever taken medication to bring on period? YES NO
Have you ever used the Oral Contraceptive Pill? YES NO
Which one? _____ How long? _____
When did you last use it? _____
How long did it take for your menses to regulate after stopping? _____

When was your last pap smear? _____ Result: _____
Have you ever had an abnormal pap? YES NO
If yes, was follow up or procedure necessary? YES NO
Have you ever had a mammogram? YES NO Result:_____

Have you ever had a sexually transmitted disease? YES NO
Chlamydia, Gonorrhea, Herpes, Other:_____
When?_____ Was it treated? YES NO

I. Reproductive Medical History

Please indicate number of:

___ Pregnancies ___ Premature births
___ Children ___ Ectopic pregnancies
___ Miscarriages ___ Abortions

Surgeries/Procedures:	**Date:**
___ HSG (Hysterosalpingogram)	_____
___ Hysterostopy	_____
___ Laparoscopy	_____
___ Other:_____	_____

Hormone Levels and Lab Results:	Levels:	Date:
Estradiol		
Progesterone		
LH		
FSH		
TSH T3 T4		
Total Testosterone Free Testosterone		
DHEAS		
Prolactin		

Other:_____

Please list number of cycles: **Date(s):**

Timed Intercourse:_____ _____

IUI: _____ _____

IVF: _____ _____

Other:_____ _____

Men only: Circle all that apply

Prostatitis Impotence Blood/mucus discharge Enlarged prostate

Semen Analysis:

Sperm Count:_____ Volume:_____ Morphology:_____ Motility:_____

Liquefaction time:_____ pH:_____ White blood cell count:_____

Other test(s) and result(s):_____

II. Overall symptoms

Lung Function:

Persistent cough	Chronic allergies	Dry or flaky skin
Nose bleeds	Nasal dryness	Sneezing
Difficulty breathing	Sinus congestion	Sore throats
Wheezing	Cigarette smoking	Allergies
Profuse perspiration	Perspire easily	Lack of perspiration
Sweaty hands	Sweaty feet	

If you are a smoker, how many cigarettes do you smoke per day? _____

How long have you been smoking? _____

If you are a smoker, do you want to quit? YES NO

Level of determination to quit: 1 2 3 4 5 6 7 8 9 10

Large Intestine/Bowel Function:

Soft/Loose stools	Constipation	Difficulty moving bowels
Burning sensation	Hemorrhoids	Itchiness
I.B.S. or colitis	Diarrhea	Blood in stools
Mucus in stools	Small, hard or dry, stools	Crohn's disease
Incomplete stools	Less than 1 BM/Day	Eating disorder
Painful bowel movements	Undigested food in stool	Alternating stools

Stomach Function:

Stomachache	Stomach ulcer	Acid reflux	Heartburn
Belching	Hiccups	Mouth Ulcers	Bleeding Gums
Ravenous appetite	Bad breath	Nausea	Vomiting
Strong thirst			

Spleen Function:

Energy level: HIGH MEDIUM LOW

Poor appetite	Feel heavy/sluggsh	Energy lower after a meal
Heaviness in head	Feel bloated after eating	Poor circulation
Crave sweets	Varicose Veins	Bruise easily
Loose stools	Tired around ovulation	Spot before your period comes
Abdominal pain	Tired around menstruation	Cold nose
Indigestion	Nausea	Gas
Often sick	Hypoglycemia	Abdominal distention
Mental fogginess	Swollen hands	Edema in legs
Mental sluggishness	Swollen feet	Edema in abdomen
Poor mental focus	Joint stiffness/ache	Chest congestion
Heaviness of head, limbs or whole body		

Heart Function:

Heart palpitations	Forgetfulness	Hot hands
Anxiety	Depression	Hot feet
Mental restlessness	High Blood pressure	Rapid heart beat
Chest pain	Heart murmur	Restless dreams
Hemophilia	Tongue Ulcers	Insomnia
Manic moods	Speech impediment	Arrhythmia
Severe Shyness	Low blood pressure	Wake up early AM

Liver and Gallbladder Function:

Chest pain	Irritability	Depression	Skin rashes
Chest tightness	Easy to anger	Pain in ribcage	Acne
All over body tension	Easily frustrated	Headaches	Muscle Spasms
Convulsions	Chronic neck tension	Migraines	Muscle cramps
Numbness/tingling	Shoulder tension	Gall stones	Lump in throat
Eye dryness	Seizures	Ringing in ears	PMS
Breast tenderness	Nipple pain	painful periods	

Waking up with bitter taste in mouth
Difficulty falling asleep at night
Alternation diarrhea and constipation
Easily overwhelmed by stressful circumstances

Urinary Function:

Normal color	Reddish Color	Small amount	Dribbling
Dark yellow	Cloudy	Large amount	UTI
Clear color	Strong odor	Very frequent	Pain/burning urination

Incontinence
Frequency: _____ during the day
_____ during the night

Kidney Function:

Cold hands	Hot body temperature	Afternoon flushing	Night sweating
Cold feet	Cold body temperature	Hot flashes	Night time urination

Low back weakness or pain
Fertile cervical mucus
Low back pain before period
Cold feet especially at night
Cold menstrual cramps
Colder than those around you
Vaginal dryness
Ringing in ears
Low libido
Early morning stools
Premature gray hair

Libido Function:

Normal	Diminished sex drive	Lack of desire
High sex drive	Sexual addiction	

Blood function:

Scanty or late menses	Diffculty concentrating	Weak/brittle nails
Dry skin	Dizziness	Poor night vision
Dark circles around your eyes	Fainting	Dry/brittle hair
Chapped lips	Blurry vision	Losing head hair