

# 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: (\_\_\_\_) \_\_\_\_\_

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: \_\_\_\_\_

(Leave blank for practitioner)

Effective Date: \_\_\_/\_\_\_/\_\_\_ Deductible amount: \$ \_\_\_\_\_ Deductible met? \_\_\_\_\_

If no, how much left? \$ \_\_\_\_\_ Sessions per year: \_\_\_\_\_ Coverage % \_\_\_\_\_

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

\_\_\_ Measles

\_\_\_ Chicken Pox

\_\_\_ AIDS/HIV

\_\_\_ Alcoholism

\_\_\_ Drug Addictions

\_\_\_ Asthma

\_\_\_ Birth Trauma

\_\_\_ Cancer

\_\_\_ Diabetes

\_\_\_ Emphysema

\_\_\_ Fibromyalgia

\_\_\_ Heart Disease

\_\_\_ Pacemaker

\_\_\_ Rheumatic Fever

\_\_\_ Hepatitis A/B/C

\_\_\_ Herpes

\_\_\_ Joint Replacements

\_\_\_ Lyme's Disease

\_\_\_ Lymph Nodes removed

\_\_\_ Multiple Sclerosis

\_\_\_ Polio

\_\_\_ Scarlet Fever

\_\_\_ Seasonal Allergies

\_\_\_ STDs

\_\_\_ Seizures

\_\_\_ Sinus Infections

\_\_\_ Tuberculosis

\_\_\_ Surgeries

\_\_\_ Depression

\_\_\_ Psychological Disorders

\_\_\_ 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:

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Describe your symptoms when they are at their worst:

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What makes your symptoms better:

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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? \_\_\_\_\_  
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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  
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  
Do you have premenstrual symptoms? YES NO  
If yes, 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  
If yes, how long? \_\_\_\_\_ Which one? \_\_\_\_\_  
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

**Please indicate number of:**

\_\_\_ Pregnancies                      \_\_\_ Premature births  
\_\_\_ Children                         \_\_\_ Ectopic pregnancies  
\_\_\_ Miscarriages                    \_\_\_ Abortions

**Men only: Circle all that apply**

Prostatitis                      Impotence                      Blood/mucus discharge  
Enlarged prostate

## VIII. 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/sluggish	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	Ringling 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		Vaginal dryness	
Fertile cervical mucus		Ringling in ears	
Low back pain before period		Low libido	
Cold feet especially at night		Early morning stools	
Cold menstrual cramps		Premature gray hair	
Colder than those around you			

**Libido Function:**

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

**Blood function:**

Scanty or late menses	Difficulty 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