Patient Health History Questionnaire

HealingTransformations

Date: _____

Last Name: _____ First Name: _____ Birthdate: _____

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

Phone: Home- _____ Other- _____ Age: _____

Family Physician: _____ Referred by: _____

In Emergency, Notify: _____ Phone: _____

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

Please list the primary reasons for your visit. Date of Onset:

1. _____ _____

2. _____ _____

3. _____ _____

What, if any, medical diagnosis have you been given for your symptoms? _____

_____

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

_____

Surgeries: _____

_____

Significant Trauma (accidents, etc): _____

_____

Allergies**:** _____

What are your goals for receiving acupuncture? Check all that apply:

- ☐ stress relief
- ☐ reduction in symptoms or pain: To what percentage? _____%
- ☐ greater flexibility
- ☐ better posture

☐ complete disappearance of symptoms or pain ☐ illness prevention
☐ no expectation for improvement: Why? _____

Please check any of the following symptoms that you have experienced in the last three months:

General

☐ poor appetite
☐ cravings
☐ strong thirst
☐ poor sleeping
☐ weight gain
☐ weight loss
☐ sweat easily
☐ fever/chills
☐ low energy
☐ bruise easily
☐ dizziness

Neuropsychological:

☐ areas of numbness
☐ seizures
☐ bad temper
☐ lack of coordination

☐ poor memory
☐ loss of balance
☐ dizziness
☐ depression
☐ anxiety
☐ confusion

Respiratory:

☐ difficulty breathing
☐ coughing blood
☐ bronchitis
☐ cough
☐ difficulty in breathing when lying down
☐ pain with a deep breath
☐ asthma
☐ phlegm

Cardiovascular:

☐ blood clots
☐ high blood pressure
☐ cold hands or feet
☐ swelling of hands/feet
☐ chest pain
☐ palpitations
☐ fainting

Skin and Hair:

☐ rashes
☐ loss of hair
☐ itching
☐ eczema

Gastrointestinal:

☐ constipation
☐ hemorrhoids
☐ black stools
☐ rectal pain
☐ diarrhea
☐ nausea
☐ bad breath
☐ abdominal pain or cramps
☐ vomiting
☐ gas

☐ belching
☐ indigestion/heartburn

Head, eyes, ears, nose & throat:

☐ poor vision
☐ eye strain/pain
☐ ringing in ears
☐ poor hearing
☐ nose bleeds
☐ mouth sores
☐ earaches
☐ teeth problems
☐ sinus problems
☐ headaches
☐ grinding teeth

Pregnancy and Gynecology:

- ☐ clots
- ☐ vaginal discharge
- ☐ vaginal sores
- ☐ irregular periods
- ☐ painful periods
- ☐ breast lumps

_____number of pregnancies _____number of births

_____number of miscarriages

Musculoskeletal:

- ☐ neck pain
- ☐ back pain
- ☐ hand/wrist pain
- ☐ muscle pains
- ☐ hip pain
- ☐ muscle weakness
- ☐ shoulder pain
- ☐ knee pain
- ☐ foot/ankle pain

Genito-Urinary:

- ☐ pain on urination

impotency urgency to urinate
frequent urination
sores on genitals

- ☐ decrease in flow
- ☐ unable to hold urine
- ☐ blood in urine
- ☐ kidney stones
- ☐ urgency to urinate
- ☐ frequent urination
- ☐ wake up to urinate