Sound Spirit Acupuncture

Health History Questionnaire

Name:		Date:
Street Address:		
City:	State:	Zip:
Home phone:	Work phone:	Cell:
****Please mark preferred contact number for reminder calls with a star****		
Email:		
Date of birth:	Place of Birth:	Age:
In emergency, please notify:		Phone:
How did you hear about us?		
Have you been treated by acupuncture before?	Chinese herbal medicine?	

Reason #1 for contacting our office:
Date of injury: If not an injury, when did the problem begin?
Please describe your symptoms and what makes them better or worse:
Has a medical diagnosis been given for this problem?
Previous treatment(s) you have tried and results:

Reason #2 for contacting our office:
Date of injury: If not an injury, when did the problem begin?
Please describe your symptoms and what makes them better or worse:

Has a medical diagnosis been given for this problem?
Previous treatment(s) you have tried and results:

Last doctor's appointment (date & reason for visit): _____

Please check any of the following that apply to you:

☐ Pregnant ☐ Bleeding disorder ☐ Pacemaker ☐ Hepatitis ☐ Seizures

☐ HIV ☐ High blood pressure ☐ Surgical mesh ☐ Chemo/radiation

Please describe any allergies and/or reactions (drugs, chemicals, foods, environmental):

Medications / vitamins / supplements / herbs:	Reason for taking it:

What is your history for major Illnesses/Traumas:

Surgeries:

Family medical history (stroke, heart disease, high blood pressure, cancer, skin disease, mental disorders, seizures, asthma, substance abuse, allergies, diabetes, etc.):

Mother:

Father:

Siblings:

Grandparents:

Are you on a restricted diet? ☐ Yes ☐ No Please describe:

Please pick the appropriate number to describe the amounts consumed each day on a scale of 0 (none), 1, 2, 3, 4, or 5 (heavy).

Wheat products (bread, pasta, pastries, etc.):
Grains & legumes:
Dairy products (milk, cheese, butter):
Seafood (fish & shellfish):
Animal products (meats, poultry, eggs):
Cooked vegetables:
Raw vegetables:
Water:
Sugar:
Salt:
Processed foods:

Please describe your habits by filling in the amount and frequency (daily, weekly, monthly).

Cigarettes: per: Marijuana: per: Alcohol: per:
Tea: per: Coffee: per: Soft drinks: per:

What is your work and do you enjoy it?

If not working, what are your main activities?

What is your current stress level on a scale from 1 (low) to 10 (high)?

What are the major stress factors in your life?

What do you do to relieve stress or relax?

How much time a day do you watch TV/movies? Spend on the computer?

Do you have a regular exercise program? ☐ Yes ☐ No Please describe:

What time do you fall asleep? Wake? Number of hours of sleep a night?

How long does it take you to fall asleep? Do you wake feeling rested?

Do you wake during the night? # of times: Reason:

Do you nap or rest during the day? For how long?

Please rate your general energy level on a scale from 1 (low) to 10 (high)?

What time of day is it the highest? Lowest?

Emotions have physical effects on health. Please rate the intensity with which you experience the following emotions each day on a scale of 0 (not at all), 1, 2, 3, 4, or 5 (very).
Anger:
Frustration:
Joy / happiness:
Worry / anxiety:
Sadness:
Fear / phobias:
Contentment:

Please check all that apply.

General:

☐ Poor appetite ☐ Fevers ☐ Sweat easily ☐ Localized weakness ☐ Bleed/bruise easily
☐ Peculiar tastes or smells ☐ Sudden energy drop ☐ Weight gain ☐ Weight loss
☐ Poor sleeping ☐ Chills ☐ Tremors ☐ Poor balance ☐ Fatigue ☐ Night sweats
☐ Strong thirst (for hot or cold) ☐ Thirst, but no desire to drink
☐ Cravings, for what: _____ ☐ Change in appetite

Skin and hair:

☐ Rashes ☐ Itching ☐ Dandruff ☐ Change in hair or skin ☐ Ulcerations ☐ Eczema
☐ Loss of hair ☐ Hives ☐ Pimples ☐ Recent moles
☐ Other, please specify: _____

Head, eyes, ears, nose, throat:

☐ Dizziness ☐ Glasses ☐ Poor vision ☐ Cataracts ☐ Ringing in the ears
☐ Sinus problems ☐ Teeth grinding ☐ Teeth problems ☐ Eye strain ☐ Night blindness
☐ Blurry vision ☐ Poor hearing ☐ Nose bleeds ☐ Facial pain ☐ Jaw clicks or aches
☐ Migraine ☐ Eye pain ☐ Sores on lip or inside of mouth ☐ Earaches
☐ Spots in front of eyes ☐ Recurrent sore throats
☐ Headaches, where on head: _____

Cardiovascular:

☐ High blood pressure ☐ Irregular heartbeat ☐ Cold hands and feet ☐ Blood clots
☐ Low blood pressure ☐ Dizziness ☐ Swelling of hands ☐ Phlebitis ☐ Chest pain
☐ Fainting ☐ Swelling of feet ☐ Difficulty breathing
☐ Other heart or blood vessel problems: _____

Respiratory:

☐ Cough ☐ Bronchitis ☐ Coughing blood ☐ Asthma ☐ Pain on breathing
☐ Pneumonia ☐ Sleep apnea ☐ Allergies ☐ Rhinitis ☐ Difficulty breathing lying down
☐ Shortness of breath (on exertion, walking, climbing stairs, exercising, etc.)
☐ Coughing or nose blowing with phlegm, what color?_____
☐ Other lung or breathing problems:_____

Gastrointestinal:

☐ Nausea ☐ Constipation ☐ Diarrhea ☐ Black stools ☐ Bad breath
☐ Abdominal pain or cramps ☐ Chronic laxative use ☐ Vomiting ☐ Gas
☐ Blood in stools ☐ Rectal pain ☐ Belching ☐ Indigestion ☐ Hemorrhoids
☐ Other stomach or intestinal problems:_____

Genito-urinary:

☐ Pain on urination ☐ Urgency to urinate ☐ Decrease in flow ☐ Unable to hold urine
☐ Difficulty urinating ☐ Kidney stones ☐ Blood in urine ☐ Sores on genitals

Musculoskeletal:

☐ Neck pain ☐ Back pain ☐ Hand / wrist pain ☐ Muscle pain ☐ Muscle weakness
☐ Shoulder pain ☐ Knee pain ☐ Foot / ankle pain ☐ Hip pain
☐ Other: _____

Neuropsychological:

☐ Seizures ☐ Areas of numbness ☐ Concussion ☐ Bad temper ☐ Dizziness
☐ Lack of concentration ☐ Depression ☐ Loss of balance ☐ Easily susceptible to stress
☐ Poor memory ☐ Anxiety

For women only:

☐ Sweet cravings ☐ Nervousness ☐ Took birth control pills ☐ Heavy period
☐ Tender breasts before period ☐ PMS ☐ Fluid retention ☐ Mood swings
☐ Decreased sex drive ☐ Habitual miscarriage ☐ Infertility ☐ Vaginal discharge
☐ Scanty menses ☐ Heavy menses ☐ Breast pain ☐ Uterine fibroids
☐ Breast lumps ☐ Uterine hemorrhage ☐ Irregular period ☐ No period
Age when started menses: Age when started menopause:
Pregnancies: Age:
Miscarriages: Age:
Abortions: Age:

For men only:

☐ Decreased sex drive ☐ Impotency ☐ Low sperm count ☐ Exhaustion after sex
☐ Difficult urination ☐ Nighttime urination ☐ Scanty ejaculation
☐ Premature ejaculation ☐ Loss of force when urinating ☐ Dribbling after urination

Please tell me about any other conditions you would like to address: