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): A*t 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.)? _____

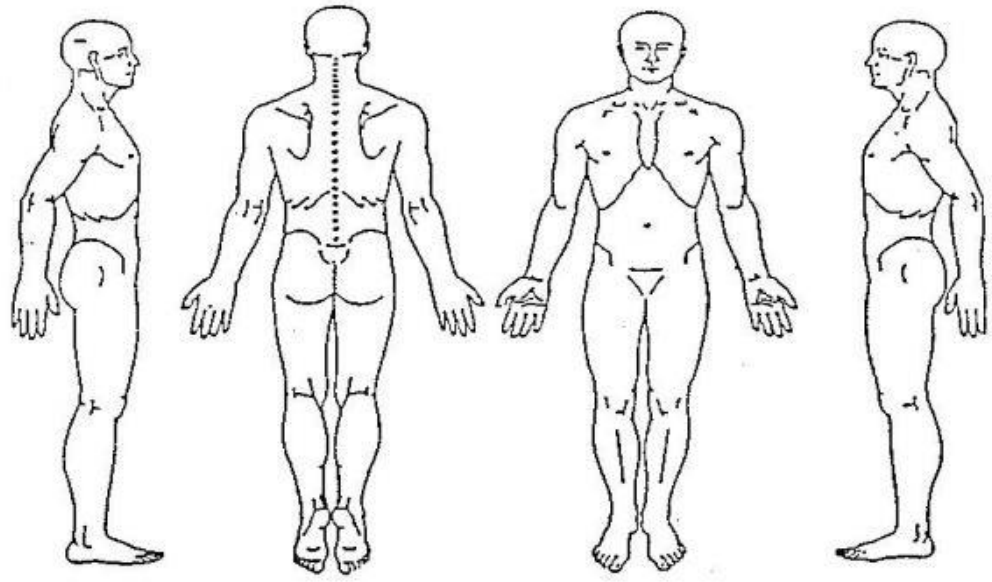
- What kinds of treatment have you tried? ☐Western Medicine ☐ Acupuncture ☐ Herbs ☐ Massage ☐ Physical Therapy

  ☐ 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:



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):

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

Current Medications:

Name of the medication	*Reason for taking*

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

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?_____

☐Irregular periods	☐Painful periods	☐Clot
☐Difficult/Painful intercourse	☐Ovarian cysts	☐Endometriosis
☐Vaginal dryness/itching	☐Vaginal sores	☐Vaginal discharge (color/amount/odor_____)
☐Uterine Fibroids	☐Polycystic Ovarian Syndrome	☐ Fibrocystic breast tissue
☐PMS	☐Breast lumps	☐Infertility
☐Sexually transmitted disease	☐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
Color (normal, bright red, pale, brown, rust, dark, purple, other)							
Amount of flow (normal, heavy, light)							
Pain/cramps (location, dull, sharp, other)							
Clots (describe size: large, small, black, purple, red, other)							
Vomiting/nauseas (check if yes)							
PMS (what symptoms, duration of symptoms)							
Other							

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:** _____