

Health History Questionnaire

Energetic Health Acupuncture & Oriental Medicine

215 Hillcrest Ave, Ste A ~ Yorkville, IL 60560

630-553-1783

Information for your Acupuncturist

Important: Please complete this document as thoroughly as possible. Some of the questions that follow may seem unrelated to your condition, but they may play a major role in diagnosis and treatment.

All information is strictly confidential

I. General Patient Information

Date: ____/____/____ Name: _____

Address: _____

City _____ State _____ Zip _____

Email _____

Home Phone: _____ Work Phone: _____

Age: _____ Date of Birth: ____/____/____ Place of Birth: _____

Guardian (if under 18): _____

Gender: [] M [] F Height: ____' ____" Weight: _____lbs.

Occupation: _____ Employer: _____

How did you hear about our office? _____

Primary Care Physician: _____

Emergency Contact: _____ Relationship: _____

Phone: _____ Cell/Work Phone: _____

Medications (Prescription & Over-the-counter): _____

Major Complaint(s), in order of significance to you:

	Severe	Moderate	Slight	Date of onset	
1.	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	_____	_____
2.	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/>	_____	_____
3.	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/>	_____	_____
4.	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/>	_____	_____
5.	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/>	_____	_____
6.	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/>	_____	_____
7.	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/>	_____	_____

Family History:

Please fill in the age and health information for family members. Place a checkmark where they have an applicable history.

	Father	Mother	Brothers	Sisters	Child	Spouse
Health (G=good; P=poor)						
Age, if living						
If deceased, age of death						
Cause of death						
Cancer						
Diabetes						
Heart Disease/ High Blood Pressure						
Stroke						
Epilepsy						
Mental Illness						
Asthma, hay fever, hives						
Anemia						
Kidney Disease						
Glaucoma						
Tuberculosis						
Other:						

Supplements (if any vitamins, herbs, minerals, etc): _____

Allergies:

Are you hypersensitive or allergic to:

Any drugs? Yes No Please
 list: _____

Any foods? Yes No Please
 list: _____

Symptom Profile

For the following, please check **YES** for a condition you have **currently** and check **PAST** for a condition you've had in the past, noting the date in the space provided.

Skin disorders:

Currently have?	YES	PAST	WHEN?
Acne, Boils	<input type="checkbox"/>	<input type="checkbox"/>	_____
Acute Hair Loss	<input type="checkbox"/>	<input type="checkbox"/>	_____
Color Change	<input type="checkbox"/>	<input type="checkbox"/>	_____
Eczema, Hives	<input type="checkbox"/>	<input type="checkbox"/>	_____
Itching	<input type="checkbox"/>	<input type="checkbox"/>	_____

Nail Fungus	<input type="checkbox"/>	<input type="checkbox"/>	_____
Dry Skin	<input type="checkbox"/>	<input type="checkbox"/>	_____
Rash	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other _____	<input type="checkbox"/>	<input type="checkbox"/>	_____

Respiratory System Disorders:

Currently have? YES PAST WHEN?

Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Chronic Asthma	<input type="checkbox"/>	<input type="checkbox"/>	_____
Chronic Cough	<input type="checkbox"/>	<input type="checkbox"/>	_____
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	_____
Frequent Colds	<input type="checkbox"/>	<input type="checkbox"/>	_____
Pain in Breathing	<input type="checkbox"/>	<input type="checkbox"/>	_____
Pleurisy	<input type="checkbox"/>	<input type="checkbox"/>	_____
Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>	_____
Shortness of Breath	<input type="checkbox"/>	<input type="checkbox"/>	_____
Sinus Congestion	<input type="checkbox"/>	<input type="checkbox"/>	_____
Spitting up Blood	<input type="checkbox"/>	<input type="checkbox"/>	_____
Temporary Cough	<input type="checkbox"/>	<input type="checkbox"/>	_____
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Nasal drainage	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other_____	<input type="checkbox"/>	<input type="checkbox"/>	_____

Emotional or Mental Illness:

Currently have?	YES	PAST	WHEN?
Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	_____
Depression	<input type="checkbox"/>	<input type="checkbox"/>	_____
Considered or Attempted Suicide	<input type="checkbox"/>	<input type="checkbox"/>	_____
Irritability	<input type="checkbox"/>	<input type="checkbox"/>	_____
Mood Swings	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other_____	<input type="checkbox"/>	<input type="checkbox"/>	_____

Head, Ear, Eyes, Nose, Throat:

Currently have:	YES	PAST	WHEN?
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	_____
Migraines	<input type="checkbox"/>	<input type="checkbox"/>	_____
Head Injury	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>	_____

Ears:	YES	PAST	WHEN?
Earaches	<input type="checkbox"/>	<input type="checkbox"/>	_____
Ringing in Ears	<input type="checkbox"/>	<input type="checkbox"/>	_____
Impaired Hearing	<input type="checkbox"/>	<input type="checkbox"/>	_____
Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	_____

Eyes:			
Cataracts	<input type="checkbox"/>	<input type="checkbox"/>	_____
Color Blindness	<input type="checkbox"/>	<input type="checkbox"/>	_____
Contacts or Glasses	<input type="checkbox"/>	<input type="checkbox"/>	_____
Double Vision	<input type="checkbox"/>	<input type="checkbox"/>	_____
Eye Pain or Strain	<input type="checkbox"/>	<input type="checkbox"/>	_____
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	_____
Impaired Vision	<input type="checkbox"/>	<input type="checkbox"/>	_____
Tearing or Dryness	<input type="checkbox"/>	<input type="checkbox"/>	_____
Spots in Front of Eyes	<input type="checkbox"/>	<input type="checkbox"/>	_____

Nose:			
Nose Bleeds	<input type="checkbox"/>	<input type="checkbox"/>	_____
Loss of Smell	<input type="checkbox"/>	<input type="checkbox"/>	_____

Mouth:			
Bleeding Gums	<input type="checkbox"/>	<input type="checkbox"/>	_____
Dental Cavities	<input type="checkbox"/>	<input type="checkbox"/>	_____

Dry Mouth	<input type="checkbox"/>	<input type="checkbox"/>	_____
Oral Sores	<input type="checkbox"/>	<input type="checkbox"/>	_____
Oral Thrush	<input type="checkbox"/>	<input type="checkbox"/>	_____
Teeth Grinding	<input type="checkbox"/>	<input type="checkbox"/>	_____
Jaw Problems, TMJ	<input type="checkbox"/>	<input type="checkbox"/>	_____

Throat:

Currently have?	YES	PAST	WHEN?
Goiter	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hoarseness	<input type="checkbox"/>	<input type="checkbox"/>	_____
Swollen Glands	<input type="checkbox"/>	<input type="checkbox"/>	_____
Trouble Swallowing	<input type="checkbox"/>	<input type="checkbox"/>	_____
Neck Pain/Stiffness	<input type="checkbox"/>	<input type="checkbox"/>	_____
Frequent Sore Throat	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other_____	<input type="checkbox"/>	<input type="checkbox"/>	_____

Digestive Disorders:

Currently have?	YES	PAST	WHEN?
Nausea	<input type="checkbox"/>	<input type="checkbox"/>	_____
Vomiting	<input type="checkbox"/>	<input type="checkbox"/>	_____
Loss of Appetite	<input type="checkbox"/>	<input type="checkbox"/>	_____
Ulcer	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heartburn	<input type="checkbox"/>	<input type="checkbox"/>	_____
Gas or bloating	<input type="checkbox"/>	<input type="checkbox"/>	_____
Internal Cramping	<input type="checkbox"/>	<input type="checkbox"/>	_____
Constipation	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	_____
Loose Stool	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hemorrhoids	<input type="checkbox"/>	<input type="checkbox"/>	_____
Bowel Movement Frequency?			_____
Is this a change? <input type="checkbox"/>			_____
Other_____	<input type="checkbox"/>	<input type="checkbox"/>	_____

Cardiovascular Disorders:

Currently have?	YES	PAST	WHEN?
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Endocarditis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	_____
Palpitations or fluttering	<input type="checkbox"/>	<input type="checkbox"/>	_____
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	_____
Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	_____
Phlebitis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Blood Clots	<input type="checkbox"/>	<input type="checkbox"/>	_____
Ankle Swelling	<input type="checkbox"/>	<input type="checkbox"/>	_____
Fainting	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other_____	<input type="checkbox"/>	<input type="checkbox"/>	_____

Urinary Tract Disorders:

Currently have?	YES	PAST	WHEN?
Frequent infection	<input type="checkbox"/>	<input type="checkbox"/>	_____
Frequent Night Urination	<input type="checkbox"/>	<input type="checkbox"/>	_____
Inability to hold urine	<input type="checkbox"/>	<input type="checkbox"/>	_____
Burning or pain during urination	<input type="checkbox"/>	<input type="checkbox"/>	_____
Increased frequency	<input type="checkbox"/>	<input type="checkbox"/>	_____
Kidney stones	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other_____	<input type="checkbox"/>	<input type="checkbox"/>	_____

Musculoskeletal Disorders:

Currently have? YES PAST WHEN?

Weakness _____

Muscle Spasms or cramps _____

Joint pain, swelling, or stiffness _____

Sciatica _____

Fibromyalgia _____

Broken bones _____

Any other pain _____

Location: _____

Other _____ _____

Miscellaneous:

Currently have? YES PAST WHEN?

Easy bleeding or bruising _____

Varicose veins _____

Anemia _____

Slow wound healing _____

Chronic infections _____

Day sweats _____

Night sweats _____

Cold hands or feet _____

Heat or cold intolerance _____

Fatigue _____

Chronic fatigue syndrome _____

Hypoglycemia _____

Hyperthyroid _____

Excessive Thirst _____

Excessive hunger _____

Diabetes _____

Gallbladder disease _____

Liver disease _____

Jaundice _____

Hepatitis _____

Type? _____

Other _____ _____

Lifestyle Habits:

Do you...

Exercise? No Yes

What kind? _____

How often? _____

Take vacations? No Yes

How often? _____

Tobacco, food and drink habits:

Do you...

Use tobacco No Yes

How much/how often? _____

Smoked previously? No Yes

How long? _____

How many packs a day? _____

Ever been treated for drug dependence? No Yes

Drink Alcohol? No Yes

How much/often? _____

Drink caffeinated beverages? No Yes

How much/often? _____

Eat out? No Yes

Times per week? _____

Sleep habits:

Do you...

Sleep well? No Yes

Awaken rested No Yes

Average 6-8 hrs sleep No Yes

Spend time outside No Yes

What time of day is your energy at its best? _____

How many meals to you eat per day? _____

Go on diets often? No Yes

Typical food intake:

Breakfast _____

Lunch _____

Dinner _____

Snacks _____

Which selection most closely describes your diet? (You may check more than one item)

- Vegan Raw Foods Vegetarian Mostly Vegetarian Low fat Low carb Allergy conscious
- Fast food/restaurants Ethnic Typical American

Which of these selections do you take daily (3 checks), several times a week (2 checks), once a week (1 check):

Sugar _____ Sugar substitutes _____ Coffee _____ Tobacco _____ Red Meat _____ Alcohol _____ Diet drinks _____

Any history of psychological, physical or sexual abuse? No Yes

FOR MEN ONLY:

Do you now, or have you ever had...?

- | | | | |
|--------------------------------|-----------------------------|------------------------------|-------------|
| Testicular masses | <input type="checkbox"/> No | <input type="checkbox"/> Yes | When? _____ |
| Testicular pain | <input type="checkbox"/> No | <input type="checkbox"/> Yes | When? _____ |
| Prostate Disease | <input type="checkbox"/> No | <input type="checkbox"/> Yes | When? _____ |
| Impotence | <input type="checkbox"/> No | <input type="checkbox"/> Yes | When? _____ |
| Premature ejaculation | <input type="checkbox"/> No | <input type="checkbox"/> Yes | When? _____ |
| Hernias | <input type="checkbox"/> No | <input type="checkbox"/> Yes | When? _____ |
| Condyloma | <input type="checkbox"/> No | <input type="checkbox"/> Yes | When? _____ |
| Syphilis | <input type="checkbox"/> No | <input type="checkbox"/> Yes | When? _____ |
| Genital, oral or rectal herpes | <input type="checkbox"/> No | <input type="checkbox"/> Yes | When? _____ |
| Gonorrhea | <input type="checkbox"/> No | <input type="checkbox"/> Yes | When? _____ |
| Other _____ | <input type="checkbox"/> No | <input type="checkbox"/> Yes | When? _____ |

FOR WOMEN ONLY:

Do you now, or have you ever had...?

- | | | | |
|----------------------------------|-----------------------------|------------------------------|-------------|
| Breast lumps | <input type="checkbox"/> No | <input type="checkbox"/> Yes | When? _____ |
| Nipple discharge | <input type="checkbox"/> No | <input type="checkbox"/> Yes | When? _____ |
| Breast pain or tenderness | <input type="checkbox"/> No | <input type="checkbox"/> Yes | When? _____ |
| Abnormal PAP smear | <input type="checkbox"/> No | <input type="checkbox"/> Yes | When? _____ |
| Cervical displasia | <input type="checkbox"/> No | <input type="checkbox"/> Yes | When? _____ |
| Vaginal discharge | <input type="checkbox"/> No | <input type="checkbox"/> Yes | When? _____ |
| Gonorrhea | <input type="checkbox"/> No | <input type="checkbox"/> Yes | When? _____ |
| Syphilis | <input type="checkbox"/> No | <input type="checkbox"/> Yes | When? _____ |
| Genital, oral or rectal herpes | <input type="checkbox"/> No | <input type="checkbox"/> Yes | When? _____ |
| Condyloma | <input type="checkbox"/> No | <input type="checkbox"/> Yes | When? _____ |
| Fibroids | <input type="checkbox"/> No | <input type="checkbox"/> Yes | When? _____ |
| Ovarian cysts | <input type="checkbox"/> No | <input type="checkbox"/> Yes | When? _____ |
| Sexual difficulties | <input type="checkbox"/> No | <input type="checkbox"/> Yes | When? _____ |
| Are you on birth control? | <input type="checkbox"/> No | <input type="checkbox"/> Yes | When? _____ |
| Number of pregnancies _____ | | | |
| Number of live births _____ | | | |
| Number of miscarriages _____ | | | |
| Number of abortions _____ | | | |
| Age at first menses _____ | | | |
| Length of cycle in days _____ | | | |
| Duration of period in days _____ | | | |
| PMS symptoms | <input type="checkbox"/> No | <input type="checkbox"/> Yes | When? _____ |
| Painful menses | <input type="checkbox"/> No | <input type="checkbox"/> Yes | When? _____ |
| Clotting during menses | <input type="checkbox"/> No | <input type="checkbox"/> Yes | When? _____ |
| Bleeding between periods | <input type="checkbox"/> No | <input type="checkbox"/> Yes | When? _____ |
| Menopausal symptoms | <input type="checkbox"/> No | <input type="checkbox"/> Yes | When? _____ |
| Other _____ | <input type="checkbox"/> No | <input type="checkbox"/> Yes | When? _____ |